

CERTIFICATE OF DEATH

04131
Reg. Dist. No.

4145

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3mos. 4days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS None			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jacob Middle Snively Last Adams				4. DATE OF DEATH Month April Day 7 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 3 Days 20		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Adams				14. MOTHER'S MAIDEN NAME India Nola Warford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 236-44-4897		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 3, 1959 , to April 7, 1959 , that I last saw the deceased alive on April 6, 1959 , and that death occurred at 12:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/7/59							
ACTUAL SIGNATURE Agustin del Campo M.D.				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 10-59		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
22d. LOCATION (City, town, or county) (State) Williamsport Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport Md				24a. REC'D BY REGISTRAR DATE APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4146

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont 10X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			d. STREET ADDRESS RFD #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Lewis Last Baker			4. DATE OF DEATH Month April Day 27 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1878	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME August Baker			14. MOTHER'S MAIDEN NAME Mary -		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-1086		INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22 , 19 59 , to April 27 , 19 59 , that I last saw the deceased alive on April 27 , 19 59 , and that death occurred at 7:43P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/28/59					
ACTUAL SIGNATURE Edmund Lusthaus		M.D. Springfield Hospital			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 30, 1959	22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Guagen		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

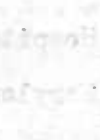
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

04138

CERTIFICATE OF DEATH

6116



DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

Signature of Registrar

Signature of Doctor

Signature of Family

Signature of Witness

CERTIFICATE OF DEATH

Reg. Dist. No.

04133

4147

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaptico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS c/o Post Office	
3. NAME OF DECEASED (Type or print) First Agnes Middle Barnes Last Barnes		4. DATE OF DEATH Month April Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-1885
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 74 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Short		14. MOTHER'S MAIDEN NAME Nellie Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Agnes Barnes		Address Chaptico, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency (Accident) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis (c) Minimal pulmonary tuberculosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 5, 1959 to April 16, 1959 , that I last saw the deceased alive on April 16, 1959 , and that death occurred at 8:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgars M. Maculans M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland	
DATE SIGNED 4-16-59			
PHYSICIAN'S NAME (Type) Edgars M. Maculans		Henryton State Hospital, Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/59	22c. NAME OF CEMETERY OR CREMATORY St Joseph	22d. LOCATION (City, town, or county) (State) Morgana Md
23. FUNERAL DIRECTOR'S SIGNATURE W. Clark Watterly		ADDRESS Leonardtown, Md	
24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04134

Reg. Dist. No.

4148

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1mo. 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney 15x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Box 194, Brookgrove Farm		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Sylvester Last Barr				4. DATE OF DEATH Month April Day 7 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 22, 1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from February 9, 1959 to April 7, 1959 , that I last saw the deceased alive on April 6, 1959 , and that death occurred at 12:10A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo M.D.				ADDRESS (Street, city or town, state) Springfield Hospital		DATE SIGNED 4/7/59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/9/59		22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON		22d. LOCATION (City, town, or county) (State) Kings Rd Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas				ADDRESS 254 Carroll St		24a. REC'D BY REGISTRAR DATE APR 10 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1c, 2, 9 Film G241 4-28-59 et
4149
CERTIFICATE OF DEATH

04135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 12Ys. 6Ms. 6Ds.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md. Hancock 21X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospittal				d. STREET ADDRESS /Same ----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry First Cornelius Middle Bishop Last				4. DATE OF DEATH April Month 18 Day 1959 Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1911 47 yrs.	
9. AGE (In years last birthday) 47		10. IF UNDER 1 YEAR Months 17 Days 48 Hours 48 Min.		11. BIRTHPLACE (State or foreign country) Fulton, Pa.		12. CITIZEN OF WHAT COUNTRY? Hancock, Md	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Different jobs				10b. KIND OF BUSINESS OR INDUSTRY same		11. BIRTHPLACE (State or foreign country) Fulton, Pa.	
13. FATHER'S NAME Andrew Bishop				14. MOTHER'S MAIDEN NAME Marie Booth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Statist. date sheet Springfield Ste. Hosp. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Partial ankylosis of all Extremities PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia paranoid type INTERVAL BETWEEN ONSET AND DEATH one hour							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 19 53 to 17 th of Apr 19 59 , that I last saw the deceased alive on April, 17 19 59 , and that death occurred at 7:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) April 18 1959 DATE SIGNED							
ACTUAL SIGNATURE Myron Nizankowsky M.D.				PHYSICIAN'S NAME (Type) Myron Nizankowsky			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4.21.59		22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Warfordsburg Fulton Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Moore Hancock Md ADDRESS				24a. REC'D BY REGISTRAR APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

1913

See back for instructions

NAME OF DECEASED John Edward Smith		DATE OF BIRTH March 15, 1885	
RESIDENCE 1234 North Avenue, Baltimore, Md.		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Bookkeeper		CAUSE OF DEATH Heart Disease	
DATE OF DEATH April 10, 1913		PLACE OF DEATH Home	
TIME OF DEATH 10:30 AM		SEX Male	
AGE 28		MARRIAGE Married	
EDUCATION High School		RELIGION Methodist	
MANNER OF DEATH Natural		SIGNATURE OF DECEASED John E. Smith	
SIGNATURE OF WITNESS John E. Smith		SIGNATURE OF PHYSICIAN Dr. J. H. Jones	
SIGNATURE OF CLERK John E. Smith		SIGNATURE OF REGISTRAR John E. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4150

CERTIFICATE OF DEATH

04136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>304 York Street</u>		d. STREET ADDRESS <u>304 York Street</u>	
3. NAME OF DECEASED (Type or print) <u>Lora</u> First <u>P. Burkheim</u> Middle <u>P.</u> Last <u>Burkheim</u>		4. DATE OF DEATH <u>April</u> Month <u>25</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Managerial Sales Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward Burkheim</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Thies</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>420-1</u>	
17. INFORMANT <u>Mrs Charles E. Miller</u> Address <u>Manchester, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5 yrs</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>48</u> , to <u>April 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foward</u> M.D.		ADDRESS (Street, city or town, state) <u>Manchester, Md</u> DATE SIGNED <u>4/27/59</u>	
PHYSICIAN'S NAME (Type) <u>W H Foward M.D</u>		<u>Manchester, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Burkheim Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Manchester, Md</u> <u>Carroll Co</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fredrick Bucher</u> ADDRESS <u>Hammer St</u>		24a. REC'D BY REGISTRAR <u>APR 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04137

Reg. Dist. No.

4151

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 mo. 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 611 Ensor Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle NMN Last CASCIO				4. DATE OF DEATH Month April Day 15 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/4/88	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Paul Cascio				14. MOTHER'S MAIDEN NAME Angela Dentico			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from February 25 19 59 , to April 15 19 59 , that I last saw the deceased alive on April 15 19 59 , and that death occurred at 10:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital 4/15/59 PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE APR 20 '59	
				24b. REGISTRAR'S SIGNATURE C. J. Ruck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4152

CERTIFICATE OF DEATH

Reg. Dist. No.

04138

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Bennett Branch Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Melissa Middle A. Last Cline		4. DATE OF DEATH Month April Day 12 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1873
9. AGE (In years last birthday) 85 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Clagettville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Issac Moxley		14. MOTHER'S MAIDEN NAME Margaret Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Wm. Boughan, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart Disease 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Chro Endocarditis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 , to Apr 12 1959 , that I last saw the deceased alive on Apr 12 1959 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE CM Van Poole		DATE SIGNED 4-13-59	
PHYSICIAN'S NAME (Type) CM Van Poole			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/59	
22c. NAME OF CEMETERY OR CREMATORY Pine Grove		22d. LOCATION (City, town, or county) (State) Mt. Airy, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Wolosworth		24a. REC'D BY REGISTRAR DATE APR 15 '59	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	

CERTIFICATE OF DEATH

DECEASED NAME Mrs. Mary 2 Bennett Branch Rd. Baltimore, Md.		PLACE OF DEATH HOME 2 Bennett Branch Rd. Baltimore, Md.	
SEX Female		AGE 65	
DATE OF DEATH Nov. 10, 1937		TIME OF DEATH 11:00 AM	
PLACE OF BIRTH Kansas, Mo.		DATE OF BIRTH Nov. 10, 1872	
OCCUPATION None		CAUSE OF DEATH Heart Failure	
MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN J. M. Smith	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES J. M. Smith, M.D. J. M. Smith, M.D.	
SIGNATURE OF REGISTRAR J. M. Smith		SIGNATURE OF CLERK J. M. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04139

4153

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster R-2		c. LENGTH OF STAY IN 1b 6 Weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover, Pennsylvania.		75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow View Convalescent Home		d. STREET ADDRESS 592 Baltimore Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maggie Middle Maude Last Clouser		4. DATE OF DEATH Month 4/22/59 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/1872
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework, Ret.		10b. KIND OF BUSINESS OR INDUSTRY Her own home	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob H. Koons		14. MOTHER'S MAIDEN NAME Phoebe Kiser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 198-07-8705	
17. INFORMANT C. Melvin Clouser, 327 Frederick St., Hanover, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pyelonephritis with Hydronephrosis 600.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis 15 years INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-14 , 19 59 , to 4-22 , 19 59 , that I last saw the deceased alive on 4-28 , 19 59 , and that death occurred at 11:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12 W. King St. Littlestown, Pa DATE SIGNED 4-22-59 ACTUAL SIGNATURE R. L. Potter PHYSICIAN'S NAME (Type) L. L. POTTER M.D. 12 W. KING ST. LITTLESTOWN, PA			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/59	
22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Littlestown, Adams Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		24a. REC'D BY REGISTRAR DATE APR 24 '59	
ADDRESS Littlestown, Pa.		24b. REGISTRAR'S SIGNATURE Arthur S. Little	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04140

4154

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Baltimore Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 29yrs.6mos.3days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore 24		03X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 306 North Point Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daisy Middle Crafton Last Crafton				4. DATE OF DEATH Month April Day 30 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1907	
				9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dudley J. Crafton				14. MOTHER'S MAIDEN NAME Barbara Frank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhages right lung due to fractured ribs DUE TO (c) -</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH Days 2 wks. plus</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. of unknown or unspecified cause with psychotic reaction. Parkinson's Disease.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown					
20c. TIME OF INJURY Month, Day, Year Hour Unknown 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James T. Marsh</i> EXAMINER'S NAME (Type) James T. Marsh, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 4/30/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/1959		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Brooks Bradley</i> ADDRESS Dundalk 22				24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

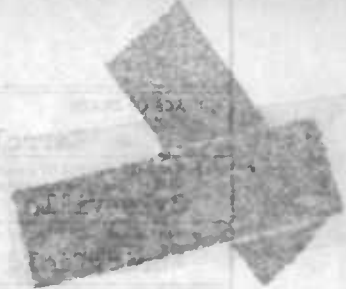
4155

CERTIFICATE OF DEATH

04141
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 29yrs. 2mos. 13days Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 2500 Reisterstown Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle James Last Crook				4. DATE OF DEATH Month April Day 19 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1897	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James W. Crook				14. MOTHER'S MAIDEN NAME Mary E. Quinn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type.							
INTERVAL BETWEEN ONSET AND DEATH Hours 332x Years 332x Years 332x							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to April 19, 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 10: P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/20/59							
ACTUAL SIGNATURE Agustin del Campo M.D.				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-22-59		22c. NAME OF CEMETERY OR CREMATORY St. Augustines Cem.	
22d. LOCATION (City, town, or county) (State) Elkridge, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thoma	

CERTIFICATE OF DEATH



Burial
Howard H. Hubbard #107 Wilkens Avenue
St. Augustines Cem. Ellicott City, Maryland

4141

CERTIFICATE OF DEATH

04142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4 Ward Ave.</u>				d. STREET ADDRESS <u>1 4 Ward Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HERBERT CROWL</u>				4. DATE OF DEATH Month Day Year <u>April 10 19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31, 1881</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Union Mills, Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Crowl</u>				14. MOTHER'S MAIDEN NAME <u>Anna Benkert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-26-60012</u>		17. INFORMANT Address <u>Mr. Wm H. Crowl 4 Ward Ave. Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal disease</u> <u>442X</u> DUE TO <u>cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis (General)</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Nov 19 - 1955</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 17</u> , 19 <u>55</u> , to <u>April 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Westminster Md April 11 - 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>H. Mary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hillman Run, Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 59</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4156

CERTIFICATE OF DEATH

04143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 603 Collett Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Davis, Jr.				4. DATE OF DEATH Month Day Year April 3, 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1910	
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) Galesville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Davis, Sr.				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Charles Davis, Jr. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency DUE TO Far advanced bilateral extensive pulmonary TB with bilateral cavitation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 19 59 , to April 3, 19 59 , that I last saw the deceased alive on April 3, 19 59 , and that death occurred at 6:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 4-3-59							
ACTUAL SIGNATURE E. M. Maculans		M.D. Henryton, Maryland					
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt.		Henryton State Hospital, Henryton, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-9-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Anatomy Ground		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Unsworth				ADDRESS Pikesville, Md.		24a. REC'D BY REGISTRAR APR 13 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18****4157****CERTIFICATE OF DEATH****04144**
Reg. Dist. No. **74**

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Maryland		c. LENGTH OF STAY IN TB 154 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 329 Frederick Street	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Davis, Sr.		4. DATE OF DEATH Month April Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1899
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY West. Md. R. R.	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William R. Davis	
14. MOTHER'S MAIDEN NAME Susan Bates		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 705-10-4953		17. INFORMANT John H. Davis, Sr. - Patient	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced bilateral pulm. tbc. c cavitation (c) Thrombophlebitis of the left leg.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 5, 19 58 , to April 8, 19 59 , that I last saw the deceased alive on April 8, 19 59 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. M. Maculans, M. D.		ADDRESS (Street, city or town, state) Henryton, Maryland	
DATE SIGNED 4-8-59			
PHYSICIAN'S NAME (Type) E. M. Maculans, M. D.		Henryton State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-11-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hager Funeral Service		ADDRESS Cumberland Md	
24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

4142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>3 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>42 CARROLL ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL AUSTIN DAY</u>				4. DATE OF DEATH Month Day Year <u>APRIL 30 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 26, 1956</u> 3 yrs.	
9. AGE (In years last birthday) <u>3</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>H. LEROY DAY</u>		14. MOTHER'S MAIDEN NAME <u>MARY CATHERINE KNILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>H. LEROY DAY, WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE LYMPHATIC LEUKEMIA</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>11 MOS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County) (State)			
21. I certify that I attended the deceased from <u>APRIL 25, 1959</u> , to <u>APRIL 30, 1959</u> , that I last saw the deceased alive on <u>APRIL 30, 1959</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William I. Stewart,</u> M.D.				ADDRESS (Street, city or town, state) <u>19 N. CHURCH ST. WESTMINSTER, MD</u>			
DATE SIGNED <u>4/30/59</u>				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAY 2, 1959</u>		<u>PLEASANT VALLEY CEM.</u>		<u>Pleasant Valley Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. E. Myers, Jr., Westminster, Md.</u>				24. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAY 4 '59</u>				24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-12

CERTIFICATE OF DEATH

11-12

Page No.

<p>1. Name of deceased</p> <p><i>John J. Smith</i></p>		<p>2. Sex</p> <p><i>Male</i></p>		<p>3. Age</p> <p><i>45</i></p>	
<p>4. Date of death</p> <p><i>March 1, 1912</i></p>		<p>5. Time of death</p> <p><i>10:30 AM</i></p>		<p>6. Place of death</p> <p><i>Home</i></p>	
<p>7. Cause of death</p> <p><i>Myocardial infarction</i></p>		<p>8. Immediate cause</p> <p><i>Coronary artery disease</i></p>		<p>9. Underlying cause</p> <p><i>Arteriosclerosis</i></p>	
<p>10. Duration of illness</p> <p><i>2 weeks</i></p>		<p>11. Period of incapacity</p> <p><i>1 month</i></p>		<p>12. Date of last illness</p> <p><i>February 15, 1912</i></p>	
<p>13. Name of physician</p> <p><i>Dr. J. H. Brown</i></p>		<p>14. Name of funeral director</p> <p><i>Mr. W. H. Green</i></p>		<p>15. Name of undertaker</p> <p><i>Mr. R. L. White</i></p>	
<p>16. Name of informant</p> <p><i>John J. Smith</i></p>		<p>17. Name of witness</p> <p><i>John J. Smith</i></p>		<p>18. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>19. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>20. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>21. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>22. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>23. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>24. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>25. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>26. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>27. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>28. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>29. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>30. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>31. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>32. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>33. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>34. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>35. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>36. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>37. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>38. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>39. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>40. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>41. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>42. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>43. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>44. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>45. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>46. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>47. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>48. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>49. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>50. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>51. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>52. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>53. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>54. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>55. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>56. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>57. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>58. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>59. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>60. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>61. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>62. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>63. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>64. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>65. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>66. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>67. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>68. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>69. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>70. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>71. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>72. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>73. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>74. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>75. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>76. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>77. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>78. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>79. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>80. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>81. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>82. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>83. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>84. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>85. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>86. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>87. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>88. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>89. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>90. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>91. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>92. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>93. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>94. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>95. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>96. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>97. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>98. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>99. Name of registrar</p> <p><i>John J. Smith</i></p>	
<p>100. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>101. Name of registrar</p> <p><i>John J. Smith</i></p>		<p>102. Name of registrar</p> <p><i>John J. Smith</i></p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON ONE TB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4158

CERTIFICATE OF DEATH

04146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 15y. 9mo. 21days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Baltimore			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leonora Middle G. Last Everhart				4. DATE OF DEATH Month April Day 13 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to trauma 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prolapse of rectum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type.						INTERVAL BETWEEN ONSET AND DEATH hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				(County) Baltimore		(State) Md.	
21. I certify that I attended the deceased from October 20, 1954 , to April 13, 1959 , that I last saw the deceased alive on April 13, 1959 , and that death occurred at 7:20 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/14/59							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Newell				24a. REC'D BY REGISTRAR APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House	

2. *Chrysomelids*

1040 JOURNAL OF POST KEYNESIAN ECONOMICS

4159

CERTIFICATE OF DEATH

04147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 9mths 6dys.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (204 S. Calhoun St.) 3 Vol. 4	
f. STREET ADDRESS 1200 Valley St. Baltimore 2		RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle James Last Fantom		4. DATE OF DEATH Month 4 Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years and birthday) 79 7		IF UNDER 1 YEAR: Months 7 Days 7 Hours 7 Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hardwood finisher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-5120	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH years years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease, Bronchopneumonia.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-27 19 58 , to 4-2 19 59 , that I last saw the deceased alive on 4-2 19 59 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustini del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 4-2-59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4/7/59	
22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		22d. LOCATION (City, town, or county) (State) Baltimore (Cedarbridge)	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Heruergans		ADDRESS 2024	
24a. REC'D BY REGISTRAR APR 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2672

150116

• 2014年12月1日 •

COLLECTIVE

+ Enigma: State Mailman

(c) The following information shall be provided:

(1) A copy of the contract or agreement between the contractor and the subcontractor.

(2) A copy of the subcontractor's schedule of work.

(3) A copy of the subcontractor's estimate of cost.

(4) A copy of the subcontractor's statement of work.

(5) A copy of the subcontractor's statement of completion.

(6) A copy of the subcontractor's statement of payment.

(7) A copy of the subcontractor's statement of change orders.

(8) A copy of the subcontractor's statement of variation orders.

(9) A copy of the subcontractor's statement of claims.

(10) A copy of the subcontractor's statement of disputes.

(11) A copy of the subcontractor's statement of arbitration.

(12) A copy of the subcontractor's statement of litigation.

(13) A copy of the subcontractor's statement of settlement.

(14) A copy of the subcontractor's statement of final account.

(15) A copy of the subcontractor's statement of final payment.

(16) A copy of the subcontractor's statement of final release.

(17) A copy of the subcontractor's statement of final certificate.

(18) A copy of the subcontractor's statement of final acceptance.

(19) A copy of the subcontractor's statement of final completion.

(20) A copy of the subcontractor's statement of final satisfaction.

(21) A copy of the subcontractor's statement of final approval.

(22) A copy of the subcontractor's statement of final sign-off.

(23) A copy of the subcontractor's statement of final closure.

(24) A copy of the subcontractor's statement of final exit.

(25) A copy of the subcontractor's statement of final departure.

(26) A copy of the subcontractor's statement of final goodbye.

(27) A copy of the subcontractor's statement of final farewell.

(28) A copy of the subcontractor's statement of final adieu.

(29) A copy of the subcontractor's statement of final au revoir.

(30) A copy of the subcontractor's statement of final until next time.

(31) A copy of the subcontractor's statement of final see you later.

(32) A copy of the subcontractor's statement of final bye-bye.

(33) A copy of the subcontractor's statement of final goodnight.

(34) A copy of the subcontractor's statement of final sleep well.

(35) A copy of the subcontractor's statement of final dream big.

(36) A copy of the subcontractor's statement of final wake up.

(37) A copy of the subcontractor's statement of final get up.

(38) A copy of the subcontractor's statement of final brush teeth.

(39) A copy of the subcontractor's statement of final wash face.

(40) A copy of the subcontractor's statement of final eat breakfast.

(41) A copy of the subcontractor's statement of final get dressed.

(42) A copy of the subcontractor's statement of final leave house.

(43) A copy of the subcontractor's statement of final catch bus.

(44) A copy of the subcontractor's statement of final arrive office.

(45) A copy of the subcontractor's statement of final start work.

(46) A copy of the subcontractor's statement of final finish work.

(47) A copy of the subcontractor's statement of final go home.

(48) A copy of the subcontractor's statement of final relax.

(49) A copy of the subcontractor's statement of final watch TV.

(50) A copy of the subcontractor's statement of final eat dinner.

(51) A copy of the subcontractor's statement of final take shower.

(52) A copy of the subcontractor's statement of final go to bed.

(53) A copy of the subcontractor's statement of final sleep peacefully.

(54) A copy of the subcontractor's statement of final wake up refreshed.

(55) A copy of the subcontractor's statement of final start new day.

(56) A copy of the subcontractor's statement of final repeat process.

(57) A copy of the subcontractor's statement of final end of world.

(58) A copy of the subcontractor's statement of final return to earth.

(59) A copy of the subcontractor's statement of final reborn again.

(60) A copy of the subcontractor's statement of final live forever.

(61) A copy of the subcontractor's statement of final achieve immortality.

(62) A copy of the subcontractor's statement of final conquer death.

(63) A copy of the subcontractor's statement of final reach enlightenment.

(64) A copy of the subcontractor's statement of final attain nirvana.

(65) A copy of the subcontractor's statement of final become Buddha.

(66) A copy of the subcontractor's statement of final become God.

(67) A copy of the subcontractor's statement of final become immortal.

(68) A copy of the subcontractor's statement of final become eternal.

(69) A copy of the subcontractor's statement of final become timeless.

(70) A copy of the subcontractor's statement of final become space-time.

(71) A copy of the subcontractor's statement of final become multi-dimensional.

(72) A copy of the subcontractor's statement of final become infinite.

(73) A copy of the subcontractor's statement of final become omnipotent.

(74) A copy of the subcontractor's statement of final become omniscient.

(75) A copy of the subcontractor's statement of final become omnipresent.

(76) A copy of the subcontractor's statement of final become omnibenevolent.

(77) A copy of the subcontractor's statement of final become omniscient-omnipotent-omnipresent-omnibenevolent.

(78) A copy of the subcontractor's statement of final become all-knowing-all-powerful-all-present-all-loving.

(79) A copy of the subcontractor's statement of final become everything.

(80) A copy of the subcontractor's statement of final become nothing.

(81) A copy of the subcontractor's statement of final become both.

(82) A copy of the subcontractor's statement of final become neither.

(83) A copy of the subcontractor's statement of final become something.

(84) A copy of the subcontractor's statement of final become nothingness.

(85) A copy of the subcontractor's statement of final become void.

(86) A copy of the subcontractor's statement of final become empty.

(87) A copy of the subcontractor's statement of final become full.

(88) A copy of the subcontractor's statement of final become complete.

(89) A copy of the subcontractor's statement of final become perfect.

(90) A copy of the subcontractor's statement of final become flawless.

(91) A copy of the subcontractor's statement of final become ideal.

(92) A copy of the subcontractor's statement of final become perfect.

(93) A copy of the subcontractor's statement of final become ideal.

(94) A copy of the subcontractor's statement of final become perfect.

(95) A copy of the subcontractor's statement of final become ideal.

(96) A copy of the subcontractor's statement of final become perfect.

(97) A copy of the subcontractor's statement of final become ideal.

(98) A copy of the subcontractor's statement of final become perfect.

(99) A copy of the subcontractor's statement of final become ideal.

(100) A copy of the subcontractor's statement of final become perfect.

[illegible]

BUNN

TOTAL

005-1-13

Editorial

Generalized Anxiety Disorder

19

• Individual and Group Exercises

• • • • •

• 100 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4160

CERTIFICATE OF DEATH

04148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 9 mos. 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Goldie Last FOGLE				4. DATE OF DEATH Month April Day 8 Year 19 59			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/12/96	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jefferson Brode		14. MOTHER'S MAIDEN NAME Ada Brigman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Yuk.		17. INFORMANT Address Springfield State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with presenile brain disease with psychotic reaction. Decubitus Ulcers.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from June 21 , 19 58 , to April 8 , 19 59 , that I last saw the deceased alive on April 8 , 19 59 , and that death occurred at 10:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/8/59							
ACTUAL SIGNATURE Edmund Lusthaus				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-59		22c. NAME OF CEMETERY OR CREMATORY Cumberland		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Otter Inc.				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 10 59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

4

4161

4161

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04149

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural) c. LENGTH OF STAY IN 1b 20yrs lmo 26ds d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5712 Bellona Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Loretta First Foos Last 4. DATE OF DEATH April Month 4 Day 59 Year		5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2 January 31, 1884 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Thomas E. Foos 14. MOTHER'S MAIDEN NAME Jane Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. - 17. INFORMANT Springfield St. Hosp. Record Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Generalised Arteriosclerosis DUE TO (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction paranoid type 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a. m. Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan. 10 , 19 59 to Apr. 23 , 19 59 , that I last saw the deceased alive on April 3 , 19 59 , and that death occurred at 4:51 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oak Str. DATE SIGNED ACTUAL SIGNATURE Konstantin Weber M.D. PHYSICIAN'S NAME (Type) KONSTANTIN WEBER SYKESVILLE , Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/7/59 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. 22d. LOCATION (City, town, or county) (State) Baltimore, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS 3331 Brehms Lane 24a. REC'D BY REGISTRAR DATE APR 8 '59 24b. REGISTRAR'S SIGNATURE Curtis S. Thane	

CERTIFICATE OF DEATH

1813

1. PLACE OF DEATH At home		2. COUNTY BALTIMORE	
3. NAME OF DECEASED JOHN J. JONES		4. SEX Male	
5. AGE 45		6. DATE OF BIRTH 1868	
7. OCCUPATION Carpenter		8. MARITAL STATUS Married	
9. CAUSE OF DEATH Heart disease		10. PLACE OF BURIAL St. John's Church	
11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
13. SIGNATURE OF DECEASED John J. Jones		14. SIGNATURE OF CLERK J. H. Smith	



1. This certificate is to be filled out by the physician or other person who has attended the deceased.

2. The cause of death should be stated in full, and the place of death should be stated.

3. The date of death should be stated.

4. The place of burial should be stated.

5. The signature of the physician or other person who has attended the deceased should be stated.

6. The signature of the witnesses should be stated.

7. The signature of the deceased should be stated.

8. The signature of the clerk should be stated.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4162
CERTIFICATE OF DEATH

04150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Frederick Co</u> b. COUNTY <u>State Maryland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> <u>10 X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weitzel Nursing Home</u>				d. STREET ADDRESS <u>Prospect Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie C Forsythe</u>				4. DATE OF DEATH Month Day Year <u>April 19 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24, 1870</u>	
9. AGE (In years last birthday) yrs. <u>88</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>88</u>		IF UNDER 24 HRS. Months Days Hours Min. <u>88</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>W. H. Collins</u>				14. MOTHER'S MAIDEN NAME <u>ANNE BUNN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				17. INFORMANT <u>Wm. A. Forsythe, 5317 Little Falls Rd. Arlington, 7. VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>several years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , to <u>April 1959</u> , that I last saw the deceased alive on <u>April 16, 1959</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4/19/59</u>							
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.				PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-21-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Wadg</u> ADDRESS <u>Winfield, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
4163											
CERTIFICATE OF DEATH											
04151											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 2yrs9mths11dys. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.					2. USUAL RESIDENCE (Where deceased lived. If institution: Distinct before admission) a. STATE Maryland b. COUNTY Montgomery 173 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7212 Spruce Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Ethel Middle Last Fowble					4. DATE OF DEATH Month 4 Day 26 Year 19 59						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-26-79		9. AGE (In years last birthday) 79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector at Mint		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Jeremiah Elms					14. MOTHER'S MAIDEN NAME Elizabeth Gartrell						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. no		INFORMANT Address Hospital records						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S., Cerebral arteriosclerosis with psychotic reaction. Bronchopneumonia										INTERVAL BETWEEN ONSET AND DEATH years years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 7-12- 1956 to 4-26- 1959 , that I last saw the deceased alive on 4-26- 1959 , and that death occurred at 3 P. M, from the causes and on the date stated above.											
ACTUAL SIGNATURE Agustin del Campo M.D.					ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 4-26-59						
PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.					Sykesville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/30/59		22c. NAME OF CEMETERY OR CREMATORY St. Lawrence		22d. LOCATION (City, town, or county) (State) St. Lawrence					
23. FUNERAL DIRECTOR'S SIGNATURE W. R. Huntman ADDRESS 5732 W. N. W.					24a. REC'D BY REGISTRAR W. R. Huntman DATE APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House				

11-11-11

DEPARTMENT OF HEALTH - BUREAU OF HEALTH

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04152

CERTIFICATE OF DEATH

Reg. Dist. No.

4164

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>				c. LENGTH OF STAY IN 1b <u>2yr.8mo.16da.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont R.F.D. #2</u>				10x-2 unknown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS -----			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Calvin</u> Last <u>Fox</u>				4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-10-11</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Fox</u>				14. MOTHER'S MAIDEN NAME <u>Olive Favorite</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic Reaction, Hebephrenic type.</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				(County) -----		(State) -----	
21. I certify that I attended the deceased from <u>4-24-56</u> , 19 <u> </u> , to <u>4-10-59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>59</u> , and that death occurred at <u>12:50</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter Knopp</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Walter Knopp, M.D.</u>				DATE SIGNED <u>4-10-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Apr. 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.B. Cem.</u>	
22d. LOCATION (City, town, or county) <u>Thurmont MD</u>				(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Cragg</u>				ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Cuthbert L. Thoms</u>							

[illegible]

†no way.

I

4165

CERTIFICATE OF DEATH

04153

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN lb 2 months 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS OLD TOWN ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle LOUISE Last GILES		4. DATE OF DEATH Month April Day 25 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 5 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Heinz H. Klaatsch		Address Springfield Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY OCCLUSION DUE TO (c) 2 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HUNTINGTONS CHOREA			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO	
20c. TIME OF INJURY Month April Day 25 Year 19 59 Hour 11 o. m. 30 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital		20f. (City or town) (County) (State) Allegheny W. Va.	
21. I certify that I attended the deceased from 2-13-1959 , to 4-25-1959 , that I last saw the deceased alive on 4-25-1959 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/25/59			
ACTUAL SIGNATURE Heinz H. Klaatsch M.D.			
PHYSICIAN'S NAME (Type) HEINZ H. KLAATSCH M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-1959	
22c. NAME OF CEMETERY OR CREMATORY Indian Mound		22d. LOCATION (City, town, or county) (State) Romney, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4166 CERTIFICATE OF DEATH

04154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3mo			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural -Sykesville				d. STREET ADDRESS 11 Walnut Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNEST Middle E. Last GRIMES				4. DATE OF DEATH Month APRIL Day 14 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-1899	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Police				10b. NAME OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William J. Grimes				14. MOTHER'S MAIDEN NAME Edna R. Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-28-6314		17. INFORMANT Address Mrs. Gertrude M. Grimes, same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Cardiac failure, 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized, DUE TO (c) to 14 April 1959						INTERVAL BETWEEN ONSET AND DEATH 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1956 , to 14 April, 1959 , that I last saw the deceased alive on 14 April, 1959 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall M.D.				ADDRESS (Street, city or town, state) Sykesville, Md DATE SIGNED 15 April 59			
PHYSICIAN'S NAME (Type) HOWARD E. HALL							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-16-1959		22c. NAME OF CEMETERY OR CREMATORY Taylorsville		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE APR 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 241 4-20-59

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04155

Reg. Dist. No.

4143

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminister			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County Jail				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle D. Last GROOMES				4. DATE OF DEATH Month April Day 12 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-18-1919	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 39 Days 39 Hours 39 Min.		IF UNDER 24 HRS. Months 39 Days 39 Hours 39 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME David A. Groomes				14. MOTHER'S MAIDEN NAME Anna R. Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ?		17. INFORMANT Address Mrs. Anna Groomes, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Skull fracture DUE TO (b) Subdural hemorrhage DUE TO (c) Contusion of brain							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell and struck head			
20c. TIME OF INJURY Month, Day, Year April 11 19 59 Hour 10:00 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Westminister Penna. Ave & Union St. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr.				DATE SIGNED 4/13/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-15-1959		22c. NAME OF CEMETERY OR CREMATORY White Rock		22d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.				24a. REC'D BY REGISTRAR DATE APR 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4167

CERTIFICATE OF DEATH

04156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUFUS Middle W. Last HALL		4. DATE OF DEATH Month APRIL Day 1 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track foreman		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William G. Hall		14. MOTHER'S MAIDEN NAME Annie Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-09-0188	
17. INFORMANT Mrs. Margaret D. Hall, same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis; Atherosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Anxiety. DUE TO (c) Generalized Anxiety.		INTERVAL BETWEEN ONSET AND DEATH Jan 59 to 1 April 59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 , to 1 April 1959 , that I last saw the deceased alive on 1 April 1959 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall M.D.		ADDRESS (Street, city or town, state) Applerville, Md DATE SIGNED 2 April 59	
PHYSICIAN'S NAME (Type) HOWARD E. HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-4-1959	
22c. NAME OF CEMETERY OR CREMATORY Poplar Springs		22d. LOCATION (City, town, or county) (State) Howard Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE APR 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF DEATH April 4, 1968		5. PLACE OF DEATH Memphis, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF BIRTH Jackson, Mississippi		14. DATE OF BIRTH January 19, 1933		15. PLACE OF DEATH Memphis, Tennessee	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF DECEASED James Earl Ray		19. SIGNATURE OF WITNESS John Edgar Hoover		20. SIGNATURE OF DECEASED James Earl Ray	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF DECEASED James Earl Ray		24. SIGNATURE OF WITNESS John Edgar Hoover		25. SIGNATURE OF DECEASED James Earl Ray	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS John Edgar Hoover		28. SIGNATURE OF DECEASED James Earl Ray		29. SIGNATURE OF WITNESS John Edgar Hoover		30. SIGNATURE OF DECEASED James Earl Ray	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF WITNESS John Edgar Hoover		33. SIGNATURE OF DECEASED James Earl Ray		34. SIGNATURE OF WITNESS John Edgar Hoover		35. SIGNATURE OF DECEASED James Earl Ray	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF WITNESS John Edgar Hoover		38. SIGNATURE OF DECEASED James Earl Ray		39. SIGNATURE OF WITNESS John Edgar Hoover		40. SIGNATURE OF DECEASED James Earl Ray	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF WITNESS John Edgar Hoover		43. SIGNATURE OF DECEASED James Earl Ray		44. SIGNATURE OF WITNESS John Edgar Hoover		45. SIGNATURE OF DECEASED James Earl Ray	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF WITNESS John Edgar Hoover		48. SIGNATURE OF DECEASED James Earl Ray		49. SIGNATURE OF WITNESS John Edgar Hoover		50. SIGNATURE OF DECEASED James Earl Ray	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF WITNESS John Edgar Hoover		53. SIGNATURE OF DECEASED James Earl Ray		54. SIGNATURE OF WITNESS John Edgar Hoover		55. SIGNATURE OF DECEASED James Earl Ray	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF WITNESS John Edgar Hoover		58. SIGNATURE OF DECEASED James Earl Ray		59. SIGNATURE OF WITNESS John Edgar Hoover		60. SIGNATURE OF DECEASED James Earl Ray	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF WITNESS John Edgar Hoover		63. SIGNATURE OF DECEASED James Earl Ray		64. SIGNATURE OF WITNESS John Edgar Hoover		65. SIGNATURE OF DECEASED James Earl Ray	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF WITNESS John Edgar Hoover		68. SIGNATURE OF DECEASED James Earl Ray		69. SIGNATURE OF WITNESS John Edgar Hoover		70. SIGNATURE OF DECEASED James Earl Ray	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF WITNESS John Edgar Hoover		73. SIGNATURE OF DECEASED James Earl Ray		74. SIGNATURE OF WITNESS John Edgar Hoover		75. SIGNATURE OF DECEASED James Earl Ray	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF WITNESS John Edgar Hoover		78. SIGNATURE OF DECEASED James Earl Ray		79. SIGNATURE OF WITNESS John Edgar Hoover		80. SIGNATURE OF DECEASED James Earl Ray	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF WITNESS John Edgar Hoover		83. SIGNATURE OF DECEASED James Earl Ray		84. SIGNATURE OF WITNESS John Edgar Hoover		85. SIGNATURE OF DECEASED James Earl Ray	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF WITNESS John Edgar Hoover		88. SIGNATURE OF DECEASED James Earl Ray		89. SIGNATURE OF WITNESS John Edgar Hoover		90. SIGNATURE OF DECEASED James Earl Ray	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF WITNESS John Edgar Hoover		93. SIGNATURE OF DECEASED James Earl Ray		94. SIGNATURE OF WITNESS John Edgar Hoover		95. SIGNATURE OF DECEASED James Earl Ray	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF WITNESS John Edgar Hoover		98. SIGNATURE OF DECEASED James Earl Ray		99. SIGNATURE OF WITNESS John Edgar Hoover		100. SIGNATURE OF DECEASED James Earl Ray	

NOTED

RECEIVED
MAY 10 1968
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

CERTIFICATE OF DEATH

Reg. Dist. No.

4169

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 30yrs2mos.17days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle L. Last Rhodes		4. DATE OF DEATH Month April Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1884
9. AGE (In years lost birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob D. Rhodes		14. MOTHER'S MAIDEN NAME Sophia Feidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involutional psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Interval BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No autopsy	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 to April 26, 1959 , that I last saw the deceased alive on April 26, 1959 , and that death occurred at 7:00P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/27/59	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 5/1/59	22c. NAME OF CEMETERY OR CREMATORY St Pauls Cem.	22d. LOCATION (City, town, or county) (State) near Clearspring Md
23. FUNERAL DIRECTOR'S SIGNATURE F. K. Hoffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove corrob. papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11132

CERTIFICATE OF DEATH

11132

Name of Deceased		Mary J. Thomas	
Sex		Female	
Date of Birth		Jan 11, 1884	
Place of Birth		New York	
Usual Residence		New York	
Cause of Death		Heart Disease	
Date of Death		Jan 11, 1924	
Place of Death		New York	
Physician		Dr. J. J. Thomas	
Burial Place		New York	
Burial Date		Jan 11, 1924	
Burial Place		New York	
Signature of Registrar		[Signature]	
Signature of Physician		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Judge		[Signature]	
Signature of Mayor		[Signature]	
Signature of County Clerk		[Signature]	
Signature of State Registrar		[Signature]	

4170

CERTIFICATE OF DEATH

04159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)				c. LENGTH OF STAY IN 1b 35 y. 4m. 11d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 125 Greene Street			
3. NAME OF DECEASED (Type or print) First Hazel Middle Hermann Last Hermann				4. DATE OF DEATH Month April Day 21 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY School			
13. FATHER'S NAME John T. Hermann				14. MOTHER'S MAIDEN NAME Maggie McCulley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 4-22-1		17. INFORMANT Springfield State Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia - Essential DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Years Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 18, 1958 , to April 21, 1959 , that I last saw the deceased alive on April 21, 1959 , and that death occurred at 5:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Konstantin Weber M.D.				ADDRESS (Street, city or town, state) Sykesville, Maryland			
DATE SIGNED 4/22/59							
PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-59		22c. NAME OF CEMETERY OR CREMATORY Cumberland		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur E. Kline				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1178

MADE IN STATE

REPORTED

DATE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A LICENSED PHYSICIAN OR A LICENSED NURSE, AND WHEN IT IS FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04160

4171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy		c. LENGTH OF STAY IN 1b 37 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle O. Last HOOPER		4. DATE OF DEATH Month APRIL Day 3 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1903
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Mercer		14. MOTHER'S MAIDEN NAME Lavinia Poole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mr. Jesse Hooper,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 3/13/59 , 19 59 , to 4/3/59 , 19 59 , that I last saw the deceased alive on 4/3/59 , 19 59 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE M. E. Robertson		M.D. New Windsor, Md.	
PHYSICIAN'S NAME (Type) M. E. ROBERTSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-6-1959	22c. NAME OF CEMETERY OR CREMATORY Taylorsville	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. SIGNATURE OF DECEASED</p>	
<p>11. SIGNATURE OF WITNESS</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>	
<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>	
<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>	
<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>	
<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>	
<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>	
<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>	
<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>	
<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>	
<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>	
<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>	
<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>	
<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>	
<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>	
<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>	
<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4172

CERTIFICATE OF DEATH

04161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 18 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural--Sykesville	
f. STREET ADDRESS Liberty Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle G. Last HOOVER		4. DATE OF DEATH Month APRIL Day 18 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Hardware	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward G. Hoover		14. MOTHER'S MAIDEN NAME Mary S. Guy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W. I		16. SOCIAL SECURITY NO. 212-09-6890	
17. INFORMANT Mrs. Margaret R. Hoover, Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY Thrombosis, Arteriosclerotic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) heart Disease, Bradycardia, Complete DUE TO (c) heart Block - Arthritis			INTERVAL BETWEEN ONSET AND DEATH 1958 18 April 59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1958 , 19____, to 18 April, 1959 , that I last saw the deceased alive on 18 April, 1959 , and that death occurred at 2:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		ADDRESS (Street, city or town, state) DATE SIGNED Agnew, Md 18 April 59	
PHYSICIAN'S NAME (Type) HOWARD E. HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-21-1959	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemty	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE APR 21 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Howard

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Heart Block - at the
is not disease, merely a
Coronary thrombosis, &

12-2-71

P2 11-9A81
9005

8651

P2 100-81

The University of Chicago Press

17. Small P. 1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4173

CERTIFICATE OF DEATH

04162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr 37 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield St. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle R. Last Pue		4. DATE OF DEATH Month April Day 18 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-71
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Pue		14. MOTHER'S MAIDEN NAME Josephine Schell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital		Address Sykesville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 19 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psych. reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-11 , 19 58 , to 4-18 , 19 59 , that I last saw the deceased alive on 4-18 , 19 59 , and that death occurred at 10:13 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 4-19-59			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04163

4174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 5218 York Road	
3. NAME OF DECEASED (Type or print) First Daisy Middle Anna Last Jordan		4. DATE OF DEATH Month April Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1908
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Parker Jordan		14. MOTHER'S MAIDEN NAME Anna Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction. Decubitus ulcer.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 9, 1959 , to April 10, 1959 , that I last saw the deceased alive on April 9, 1959 , and that death occurred at 6:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/10/59			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		DATE SIGNED 4/10/59	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-13-59	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DATE APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

CERTIFICATE OF DEATH

04164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4yrs. 4mos. 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 817 E. 17th St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Frederick Last Kettler		4. DATE OF DEATH Month April Day 20 , Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 26, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler-maker		10b. KIND OF BUSINESS OR INDUSTRY Thurman	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Frederick Kettler		14. MOTHER'S MAIDEN NAME Elizabeth Strus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Blank	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain dis., with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from March 7, 1955 , to April 20, 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 12:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 4/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-21-59	22c. NAME OF CEMETERY OR CREMATORY Freedom	22d. LOCATION (City, town, or county) (State) Sykesville, Carroll, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		24a. REC'D BY REGISTRAR DATE APR 22 '59	
ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

•

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4176

CERTIFICATE OF DEATH

04165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palatesco Md</u>		c. LENGTH OF STAY IN 1b <u>45 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Howard Benjamin Kidd</u>		4. DATE OF DEATH <u>April 29 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1876</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd N. Kidd</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Riley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-030931</u>	
17. INFORMANT <u>Mr Robert Kidd, Palatesco MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease.</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 30</u> , 19 <u>59</u> , to <u>April 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 15</u> , 19 <u>59</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Maryland</u> DATE SIGNED <u>4/29/59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carrollton Church of God</u>		22d. LOCATION (City, town, or county) (State) <u>Carrollton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Byers</u> ADDRESS <u>Westminster, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 1 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10107

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

1178

RECORDED
INDEXED
JAN 10 1910
BALTIMORE

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is mostly blank with some faint markings.

Baltimore, Maryland

Carrollton Church of God

1-10-10

1178

John R. Bore, Registrar, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4177

CERTIFICATE OF DEATH

Reg. Dist. No.

04166

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Taneytown		c. LENGTH OF STAY IN 1b 34 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taneytown, Md. R. D. 2		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Taneytown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taneytown, Md. R. D. 2		d. STREET ADDRESS Taneytown, Md. R. D. 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Stewart Middle Franklin Last King		4. DATE OF DEATH Month April Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1888
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm (Retired)	
11. BIRTHPLACE (State or foreign country) Adams Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James B. King		14. MOTHER'S MAIDEN NAME Elizabeth C. Pepple	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Carrie M. King, Littlestown, Pa. R.D.1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 38 Mos. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis. Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/21 , 19 56 , to 4/24 , 19 59 , that I last saw the deceased alive on April 20 , 19 59 , and that death occurred at 11:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. S. McVaugh M.D.		ADDRESS (Street, city or town, state) Taneytown, Md. DATE SIGNED 4/25/59	
PHYSICIAN'S NAME (Type) R. S. McVaugh			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Littlestown, Adams Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR APR 27 59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

6177

PLACE OF DEATH		DATE OF DEATH	
HOME		JANUARY 1, 1900	
NAME OF DECEASED		SEX	
JOHN J. JONES		MALE	
AGE		DATE OF BIRTH	
45		JANUARY 1, 1855	
RACE		RELIGION	
WHITE		METHODIST	
MARRIED		SINGLE	
WIDOWED		DIVORCED	
SEPARATED		OTHER	
EDUCATION		OCCUPATION	
HIGH SCHOOL		FARMER	
SCHOOLING		PROFESSION	
12		NONE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
NONE		HEART DISEASE	
TYPHOID FEVER		PNEUMONIA	
DIPHTHERIA		SCARLET FEVER	
TUBERCULOSIS		MALARIA	
SYPHILIS		LEPROSY	
OTHER		OTHER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JANUARY 1, 1900		HOME	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
J. J. JONES		J. J. JONES	
DATE		PLACE	
JANUARY 1, 1900		HOME	

4178

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 21 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Silver Spring 15-56-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 816 University Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dora Middle Daniels Last Krupnic		4. DATE OF DEATH Month April Day 29 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1895
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Daniels		14. MOTHER'S MAIDEN NAME Leah Rega	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lymphatic leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depressive reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8, 1959 , to April 29, 1959 , that I lost sown the deceased olive on April 28, 1959 , and that death occurred at 3:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/29/59 ACTUAL SIGNATURE Edmund Lusthaus M.D. Sykesville, Maryland PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons - 3501 14th Street, N.W.		24a. REC'D BY REGISTRAR DATE MAY 1 '59	
24b. REGISTRAR'S SIGNATURE Clifford S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04103

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

212

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04168

4179

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEDFORD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARY</u> Last <u>LEISTER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3-1867</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN EVERHART</u>				14. MOTHER'S MAIDEN NAME <u>MARIAH MATHIAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JAMES A LEISTER</u>		Address <u>RURAL NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> <u>422J</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>59</u> to <u>Apr 3</u> 19 <u>59</u> that I last saw the deceased alive on <u>Apr 3</u> 19 <u>59</u> and that death occurred at <u>6:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James T. March</u> M.D. <u>Apr 4/59</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/6/59</u>	
				22c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler & Sons</u>				ADDRESS <u>New Windsor, Md</u>		24a. REC'D BY REGISTRAR <u>APR 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4180

CERTIFICATE OF DEATH

04169

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b lyr. 4 mos. 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Patrick Last Leonard				4. DATE OF DEATH Month April Day 20 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 9, 1906	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min. 52		IF UNDER 24 HRS. Months 52 Days 52 Hours 52 Min. 52			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Michael Leonard				14. MOTHER'S MAIDEN NAME Cecelia Kelley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. 217-05-4982		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Mitral Stenosis IMMEDIATE CAUSE (a) 410 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with other diseases of unknown or uncertain cause with psychotic reaction.				INTERVAL BETWEEN ONSET AND DEATH years years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County) Sykesville, Maryland		20h. (State) Balto. Md.	
21. I certify that I attended the deceased from November 30, 1957 , to April 20, 1959 , that I last saw the deceased alive on April 20, 1959 , and that death occurred at 7:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/21/59 ACTUAL SIGNATURE Agustin del Campo M.D. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 24, 1959		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Edmondson Avenue, Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc., -1735 Harford Avenue, Balto. Md.				24a. REC'D BY REGISTRAR DATE APR 24 '59		24b. REGISTRAR'S SIGNATURE Clothing & Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4181

CERTIFICATE OF DEATH

04170

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R 1 Bethel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Walter Last Lockard		4. DATE OF DEATH Month April Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Howard Lockard		14. MOTHER'S MAIDEN NAME Mary Read	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - - -		16. SOCIAL SECURITY NO. 215-14-2485	
17. INFORMANT W. Holmes Lockard		Address R 1 Finksburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH about 3 years about 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from Apr. 15, 1954 , to April 22, 1959 , that I last saw the deceased alive on April 22, 1959 , and that death occurred on 9:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 4-23-59			
ACTUAL SIGNATURE C. L. Billingslea M.D.		PHYSICIAN'S NAME (Type) C. L. Billingslea, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-59	
22c. NAME OF CEMETERY OR CREMATORY Sandymount		22d. LOCATION (City, town, or county) (State) Sandymount, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR APR 27 59		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

CERTIFICATE OF DEATH

File No. 101

NAME OF DECEASED JAMES LOCKER		DATE OF DEATH April 22, 1929	
AGE 38		SEX Male	
MARRIAGE Married		OCCUPATION Carpenter	
PLACE OF BIRTH Maryland		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. B. Smith		SIGNATURE OF WITNESSES J. B. Smith, J. C. Jones	
LOCALITY Baltimore, Md.		COUNTY Baltimore	
STATE Maryland		FEDERAL BUREAU OF INVESTIGATION Baltimore, Md.	

NAME OF DECEASED JAMES LOCKER		DATE OF DEATH April 22, 1929	
AGE 38		SEX Male	
MARRIAGE Married		OCCUPATION Carpenter	
PLACE OF BIRTH Maryland		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. B. Smith		SIGNATURE OF WITNESSES J. B. Smith, J. C. Jones	
LOCALITY Baltimore, Md.		COUNTY Baltimore	
STATE Maryland		FEDERAL BUREAU OF INVESTIGATION Baltimore, Md.	

4182

CERTIFICATE OF DEATH

04171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)				c. LENGTH OF STAY IN 1b 7y. 3m. 9d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 5618 Mattfeldt Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ellen Middle Catherine Last MacDonald				4. DATE OF DEATH Month April Day 7 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 31, 1876	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Scully				14. MOTHER'S MAIDEN NAME Mary Ellen Mathews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. - -		17. INFORMANT Address Springfield State Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) INTERVAL BETWEEN ONSET AND DEATH Days Months Years							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 , to April 7, 1959 , that I last saw the deceased alive on April 7, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/7/59 ACTUAL SIGNATURE Rita S. Glahn M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Rita S. Glahn, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edm. J. Lichner & Sons - Balt., Md.				24a. REC'D BY REGISTRAR DATE APR 9 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1882

11171

See Dist. 100

PLACE OF DEATH 1. CITY		MARTIN	
2. COUNTY		BALTIMORE	
3. STATE		MD	
4. DISTRICT		100	
5. WARD		1	
6. BLOCK		1	
7. HOUSE NO.		1	
8. STREET		1	
9. CITY		BALTIMORE	
10. COUNTY		BALTIMORE	
11. STATE		MD	
12. DISTRICT		100	
13. WARD		1	
14. BLOCK		1	
15. HOUSE NO.		1	
16. STREET		1	
17. CITY		BALTIMORE	
18. COUNTY		BALTIMORE	
19. STATE		MD	
20. DISTRICT		100	
21. WARD		1	
22. BLOCK		1	
23. HOUSE NO.		1	
24. STREET		1	
25. CITY		BALTIMORE	
26. COUNTY		BALTIMORE	
27. STATE		MD	
28. DISTRICT		100	
29. WARD		1	
30. BLOCK		1	
31. HOUSE NO.		1	
32. STREET		1	
33. CITY		BALTIMORE	
34. COUNTY		BALTIMORE	
35. STATE		MD	
36. DISTRICT		100	
37. WARD		1	
38. BLOCK		1	
39. HOUSE NO.		1	
40. STREET		1	
41. CITY		BALTIMORE	
42. COUNTY		BALTIMORE	
43. STATE		MD	
44. DISTRICT		100	
45. WARD		1	
46. BLOCK		1	
47. HOUSE NO.		1	
48. STREET		1	
49. CITY		BALTIMORE	
50. COUNTY		BALTIMORE	
51. STATE		MD	
52. DISTRICT		100	
53. WARD		1	
54. BLOCK		1	
55. HOUSE NO.		1	
56. STREET		1	
57. CITY		BALTIMORE	
58. COUNTY		BALTIMORE	
59. STATE		MD	
60. DISTRICT		100	
61. WARD		1	
62. BLOCK		1	
63. HOUSE NO.		1	
64. STREET		1	
65. CITY		BALTIMORE	
66. COUNTY		BALTIMORE	
67. STATE		MD	
68. DISTRICT		100	
69. WARD		1	
70. BLOCK		1	
71. HOUSE NO.		1	
72. STREET		1	
73. CITY		BALTIMORE	
74. COUNTY		BALTIMORE	
75. STATE		MD	
76. DISTRICT		100	
77. WARD		1	
78. BLOCK		1	
79. HOUSE NO.		1	
80. STREET		1	
81. CITY		BALTIMORE	
82. COUNTY		BALTIMORE	
83. STATE		MD	
84. DISTRICT		100	
85. WARD		1	
86. BLOCK		1	
87. HOUSE NO.		1	
88. STREET		1	
89. CITY		BALTIMORE	
90. COUNTY		BALTIMORE	
91. STATE		MD	
92. DISTRICT		100	
93. WARD		1	
94. BLOCK		1	
95. HOUSE NO.		1	
96. STREET		1	
97. CITY		BALTIMORE	
98. COUNTY		BALTIMORE	
99. STATE		MD	
100. DISTRICT		100	



RECEIVED
BALTIMORE
MAY 10 1882
DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6, File G241, 4/16/59 Rev
CERTIFICATE OF DEATH

04174
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1929 St. Paul St.			
3. NAME OF DECEASED (Type or print) First Mabel Middle McHugh Last McHugh				4. DATE OF DEATH Month April Day 10 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 14, 1890	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Crawford				14. MOTHER'S MAIDEN NAME Hattie Crawford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO. 214-18-2857		17. INFORMANT John McHugh 1929 St. Paul St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia of the right cerebral hemisphere 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis years (c) Generalized arteriosclerosis years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to cardiovascular accident.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 4, 1959 , to April 10, 1959 , that I last saw the deceased alive on April 9, 1959 , and that death occurred at 4:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/10/59 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul St.				24a. REC'D BY REGISTRAR DATE APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: **John McHugh**
2. SEX: **Male**
3. AGE: **25**
4. DATE OF BIRTH: **1929 St. Paul St.**
5. PLACE OF BIRTH: **St. Paul St.**
6. OCCUPATION: **None**
7. CAUSE OF DEATH: **None**
8. PLACE OF DEATH: **None**
9. DATE OF DEATH: **None**
10. SIGNATURE OF DECEASED: **None**
11. SIGNATURE OF WITNESSES: **None**
12. SIGNATURE OF PHYSICIAN: **None**
13. SIGNATURE OF CORONER: **None**
14. SIGNATURE OF JURY: **None**
15. SIGNATURE OF JUDGE: **None**
16. SIGNATURE OF CLERK: **None**
17. SIGNATURE OF REGISTRAR: **None**
18. SIGNATURE OF ASSISTANT REGISTRAR: **None**
19. SIGNATURE OF CHIEF CLERK: **None**
20. SIGNATURE OF DEPUTY CHIEF CLERK: **None**
21. SIGNATURE OF CLERK IN CHARGE: **None**
22. SIGNATURE OF CLERK IN CHARGE: **None**
23. SIGNATURE OF CLERK IN CHARGE: **None**
24. SIGNATURE OF CLERK IN CHARGE: **None**
25. SIGNATURE OF CLERK IN CHARGE: **None**
26. SIGNATURE OF CLERK IN CHARGE: **None**
27. SIGNATURE OF CLERK IN CHARGE: **None**
28. SIGNATURE OF CLERK IN CHARGE: **None**
29. SIGNATURE OF CLERK IN CHARGE: **None**
30. SIGNATURE OF CLERK IN CHARGE: **None**

1. NAME OF DECEASED: **John McHugh**
2. SEX: **Male**
3. AGE: **25**
4. DATE OF BIRTH: **1929 St. Paul St.**
5. PLACE OF BIRTH: **St. Paul St.**
6. OCCUPATION: **None**
7. CAUSE OF DEATH: **None**
8. PLACE OF DEATH: **None**
9. DATE OF DEATH: **None**
10. SIGNATURE OF DECEASED: **None**
11. SIGNATURE OF WITNESSES: **None**
12. SIGNATURE OF PHYSICIAN: **None**
13. SIGNATURE OF CORONER: **None**
14. SIGNATURE OF JURY: **None**
15. SIGNATURE OF JUDGE: **None**
16. SIGNATURE OF CLERK: **None**
17. SIGNATURE OF REGISTRAR: **None**
18. SIGNATURE OF ASSISTANT REGISTRAR: **None**
19. SIGNATURE OF CHIEF CLERK: **None**
20. SIGNATURE OF DEPUTY CHIEF CLERK: **None**
21. SIGNATURE OF CLERK IN CHARGE: **None**
22. SIGNATURE OF CLERK IN CHARGE: **None**
23. SIGNATURE OF CLERK IN CHARGE: **None**
24. SIGNATURE OF CLERK IN CHARGE: **None**
25. SIGNATURE OF CLERK IN CHARGE: **None**
26. SIGNATURE OF CLERK IN CHARGE: **None**
27. SIGNATURE OF CLERK IN CHARGE: **None**
28. SIGNATURE OF CLERK IN CHARGE: **None**
29. SIGNATURE OF CLERK IN CHARGE: **None**
30. SIGNATURE OF CLERK IN CHARGE: **None**

4183

CERTIFICATE OF DEATH

04172

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 1, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 126 W. Camden Street	
3. NAME OF DECEASED (Type or print) First Edward Middle Alexander Last Malkowski		4. DATE OF DEATH Month 4 Day 18 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-19
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR: Months 39 Days 18 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Malkowski		14. MOTHER'S MAIDEN NAME Gertrude Golembiowski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 212-14-9833	
17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizopphrenic reaction, catatonic type			INTERVAL BETWEEN ONSET AND DEATH years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-24- 1958 to 4-18- 1959 , that I last saw the deceased alive on 4-18- 1959 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-18-59	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-21-1959	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary	22d. LOCATION (City, town, or county) (State) German Hill Rd. Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		24a. REC'D BY REGISTRAR DATE APR 21 '59	
ADDRESS 2829 Hudson St. 24, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11513

CERTIFICATE OF DEATH

11513

PLACE OF DEATH		Municipal State Hospital	
DATE OF DEATH		April 1, 1913	
AGE		34 years	
SEX		Male	
RACE		White	
BIRTH DATE		March 1, 1879	
BIRTH PLACE		Maryland	
EDUCATION		High School	
OCCUPATION		Teacher	
MANNER OF DEATH		Natural Causes	
CAUSE OF DEATH		Tuberculosis of the lungs	
PERIOD OF ILLNESS		About 6 months	
PREVIOUS ILLNESS		None	
TREATMENT		Hospital treatment	
FAMILY HISTORY		None	
SOCIAL HISTORY		None	
SIGNATURE OF PHYSICIAN		J. H. Smith, M.D.	
SIGNATURE OF REGISTRAR		J. H. Smith, M.D.	
DATE OF REGISTRATION		April 1, 1913	
PLACE OF REGISTRATION		Baltimore, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4184

CERTIFICATE OF DEATH

04173

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4yrs. 3mos. 11days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2631 N. Charles St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Lewis Last Marden		4. DATE OF DEATH Month April Day 15 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank J. Lewis		14. MOTHER'S MAIDEN NAME Columbia Troxell Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.0 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITIONS GIVEN IN PART I (a) C.B.S. assoc. with dist. of metab., growth or nutrition with senile brain disease with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 4, 19 55 to April 15, 19 59 , that I last saw the deceased alive on April 14, 19 59 , and that death occurred at 2:20A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/15/59	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 4-18-59	22c. NAME OF CEMETERY OR CREMATORY Green Mount	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE APR 17 '59	
		24b. REGISTRAR'S SIGNATURE Edmund S. Lusthaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
John Doe		Male		35		1925	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
New York City		Teacher		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE AT DEATH	
1950		Home		10:00 AM		98.6	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
[Signature]		[Signature]		1950		Baltimore	

4144

CERTIFICATE OF DEATH

04175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER-</u>				c. LENGTH OF STAY IN 1b <u>19 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LONA</u> Middle <u>MAY</u> Last <u>MICHAEL</u>				4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY / 25 / 1886</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW WINDSOR MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>DAVID O. BANKARD</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH E.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-09-6451</u>		17. INFORMANT Address <u>HUSBAND. BERNARD H. MICHAEL 59 LIBERTY WESTMINSTER,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal disease</u> <u>442 X</u> DUE TO <u>E Hypertension myocardial degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis & Bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4-10</u> <u>10-15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 17</u> , 19 <u>55</u> , to <u>April 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 15</u> , 19 <u>59</u> , and that death occurred at <u>3:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>April 21-1959</u>							
ACTUAL SIGNATURE <u>W. H. Speicher</u> M.D.				PHYSICIAN'S NAME (Type) <u>Westminster Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNION TOWN LUTHERN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN - MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Saffell</u>				ADDRESS <u>254 E MAIN ST. WESTMINSTER, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4186

CERTIFICATE OF DEATH

04176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 3yrs, 2mos, 16days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		11 X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		First Wilson		Middle Montgomery, Sr.		Last April 16, 1959	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 13, 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner - Coal Soft		10b. KIND OF BUSINESS OR INDUSTRY coal mines		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Montgomery				14. MOTHER'S MAIDEN NAME Sarah Woolf			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-09-3282		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pulmonary emphysema and fibrosis DUE TO (c) Chronic pulmonary emphysema and fibrosis		INTERVAL BETWEEN ONSET AND DEATH Days Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metab. growth or nutrition, with senile brain dis. with psychotic reaction. Intertrochanteric fracture, right femur.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 30, 1956 , to April 16, 1959 , that I last saw the deceased alive on April 16, 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/17/59							
ACTUAL SIGNATURE Agustini del Campo		W.D. Springfield Hospital		DATE SIGNED 4/17/59			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/19/1959		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) near Gorman, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE APR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
ISM 9/55

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Item 9, Film G241, 4/10/59 fcy
4187
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

04177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 6mos. 19days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Mary Middle Blanche Last Neumayer		4. DATE OF DEATH Month April Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Names -		14. MOTHER'S MAIDEN NAME Mary -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. Moderately advanced pulmonary tuberculosis.		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 002X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 17, 1956 , to April 6, 1959 , that I last saw the deceased alive on April 6, 1959 , and that death occurred at 11:58P , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/7/59 ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield Hospital PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/10/59	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	22d. LOCATION (City, town, or county) (State) Bushwood, Md
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR DATE APR 9 '59	
ADDRESS Lernardtown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

4188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville, (Rural)</u>				c. LENGTH OF STAY IN 1b <u>27y. 2m. 22d.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mazie</u> Middle <u>Gertrude</u> Last <u>O'Neal</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 16, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Frederick O'Neal</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Lashley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Springfield State Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular Disease</u> DUE TO (c) <u>Schizophrenic reaction, Other and unspecified.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>April 8, 1959</u> , that I last saw the deceased alive on <u>April 8, 1959</u> , and that death occurred at <u>8:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>4/9/59</u>							
ACTUAL SIGNATURE <u>Rita S. Glahn</u> M.D.				PHYSICIAN'S NAME (Type) <u>Rita S. Glahn, M. D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				24a. REC'D BY REGISTRAR DATE <u>APR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

For use by the

PLACE TO BE FILLED

MARYLAND

LOCAL RESIDENT (If not, specify)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

US BIRTH

US CITIZENSHIP

US RESIDENCE

US DEATH

US BURIAL

US CREMATION

US INTERMENT

US DISPOSITION

US REMAINS

US RETURN

US OTHER

US NOTES

US SIGNATURE

US DATE

US PLACE

US OFFICE

US COUNTY

US STATE

US DEPARTMENT

US DIVISION

US SECTION

US UNIT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4189

CERTIFICATE OF DEATH

04179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
4. NAME OF DECEASED (Type or print) First James Middle John Last Parker				4. DATE OF DEATH Month 4 Day 15 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-1880	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry worker-ret-molder				10b. KIND OF BUSINESS OR INDUSTRY C.L. Martin Co			
11. BIRTHPLACE (State or foreign country) Germany Austria				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Parker				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-05-8456			
17. INFORMANT Hospital records.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH years 420.0 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to cerebral arteriosclerosis. Bronchopneumonia. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4-7- 1959 , to 4-15- 1959 , that I last saw the deceased alive on 4-15- 1959 , and that death occurred at 4:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-15-59							
ACTUAL SIGNATURE Agustin del Campo M.D.				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/20/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek				ADDRESS Funeral Home		24a. REC'D BY REGISTRAR DATE APR 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur A. Foran							

1500

Small: 100

1990

10/10/2000

• *Journal of the American Medical Association*

1510

1993

21

12

1991

8. 20

[illegible]

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

[illegible]

Received 10/10/2014

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4190

CERTIFICATE OF DEATH

04180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18, Md.	
3. NAME OF DECEASED (Type or print) First Kate Middle Payton Last Payton		4. DATE OF DEATH Month 4 Day 18 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1863
9. AGE (In years last birthday) 96		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? naturalized USA	
13. FATHER'S NAME John Lutwyche		14. MOTHER'S MAIDEN NAME Elizabeth (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT S.S. Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS' assoc. with cerebral arteriosclerosis. Arteriosclerotic cardiovascular disease	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-8-1959 to 4-18-1959 , that I last saw the deceased alive on 4-18-1959 , and that death occurred at 6:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		DATE SIGNED 4-19-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-22-59	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE APR 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Hraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4191

CERTIFICATE OF DEATH

04181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN IB 8yrs.9mos.28days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 15		15x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 139 E. Bradley Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anne Middle Rackstraw Last Rackstraw		4. DATE OF DEATH Month April Day 21 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Art		10b. KIND OF BUSINESS OR INDUSTRY Teacher	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred G. Rackstraw		14. MOTHER'S MAIDEN NAME Mary Jane Tate	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis, paranoid type. Fracture, right hip.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day Year p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 , to April 21, 1959 , that I last saw the deceased alive on April 21, 1959 , and that death occurred at 4:33P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 4/22/59			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF April 22, 59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) 3201 Blandford Rd - West 24, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Bingham		ADDRESS Bethesda - Md.	
24a. REC'D BY REGISTRAR DATE APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

CERTIFICATE OF DEATH

4191

NAME OF DECEASED		JAMES H. HARRIS	
AGE		65	
SEX		Male	
DATE OF BIRTH		JAN 15 1880	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
DATE OF DEATH		JAN 25 1945	
PLACE OF DEATH		BALTIMORE, MARYLAND	
SIGNATURE OF DECEASED			
SIGNATURE OF WITNESSES			
SIGNATURE OF PHYSICIAN			
SIGNATURE OF CLERK			

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE ONE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4192

CERTIFICATE OF DEATH

04182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Rural</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hampstead</u>		d. STREET ADDRESS <u>1 Hoocksville</u>	
3. NAME OF DECEASED (Type or print) First <u>MELVIN</u> Middle <u>EARL</u> Last <u>RILL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOAH WILSON</u>		14. MOTHER'S MAIDEN NAME <u>ADA C. HIGGINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-364115</u>	
17. INFORMANT Address <u>MRS JENNIE RILL, HAMPSTEAD MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma Pancrease</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>Nov. 7</u> , 19 <u>58</u> to <u>April 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>59</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u>		DATE SIGNED <u>4/28/59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>HAMPSTEAD MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Chpton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		d. STREET ADDRESS <u>BENEDUM ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENEDUM ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE GERTRUDE PINEHART</u>				4. DATE OF DEATH Month Day Year <u>APRIL 12 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 29-1871</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT BUFFINGTON</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES CLARY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MAYBELLE BAKER UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>154X</u> DUE TO <u>Carcinoma of Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 day</u> (c) <u>from</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 1</u> , 19 <u>59</u> , to <u>Apr 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr 11</u> , 19 <u>59</u> , and that death occurred at <u>9:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> DATE SIGNED <u>Apr 12 1959</u>							
ACTUAL SIGNATURE <u>J. H. MESSLER</u> M.D.				DATE SIGNED <u>Apr 12 1959</u>			
PHYSICIAN'S NAME (Type) <u>J H MESSLER</u>				<u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. N. Barkley</u>				24a. REC'D BY REGISTRAR <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Board</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4194

CERTIFICATE OF DEATH

04184

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Md.		c. LENGTH OF STAY IN 1b 7,497 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 1116 Low Street	
3. NAME OF DECEASED (Type or print) First Middle Last John Wesley Robinson		4. DATE OF DEATH Month Day Year April 6 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 58 yrs.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY Unknown	
11c. BIRTHPLACE (State or foreign country) Parksville, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Jasper Robinson		14. MOTHER'S MAIDEN NAME Chalcey Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT John W. Robinson - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far adv. bilateral cavitory pulmonary tbc. DUE TO (c) 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 26 , 19 38 , to April 6 , 19 59 , that I last saw the deceased alive on April 6 , 19 59 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edgars M. Maculans, M.D. Henryton, Maryland 4-6-59			
ACTUAL SIGNATURE		M.D.	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		Henryton State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/10/59	22c. NAME OF CEMETERY OR CREMATORY MT. CALVARY	22d. LOCATION (City, town, or county) (State) Cedar Hill, Md
23. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson		ADDRESS 1000 Brantley Ave	
24a. REC'D BY REGISTRAR DATE APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

4195

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 mos. 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Zone 24			
f. STREET ADDRESS 4645 Park Heights Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Isadore Middle Zelick Last Sachs				4. DATE OF DEATH Month April Day 1 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 4, 1893	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? Unknown	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Russia				12. CITIZEN OF WHAT COUNTRY? Unknown			
13. FATHER'S NAME Hyman Sachs				14. MOTHER'S MAIDEN NAME Frieda Goldburn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. bronchopneumonia.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 19, 1958 to April 1, 1959 , that I last saw the deceased alive on April 1, 1959 , and that death occurred at 11:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/2/59							
ACTUAL SIGNATURE Agustin del Campo M.D. Springfield Hospital							
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4-3-59		United Hebrew		Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis				24a. REC'D BY REGISTRAR DATE APR 3 59			
24b. REGISTRAR'S SIGNATURE Wm. E. Lewis							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained in the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6241 5-1-59 et

04186

4196

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN 1b 33yr.7mo.5da.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural) Baltimore		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Springfield State Hospital	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Last Sadler		4. DATE OF DEATH Month 4 Day 22 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH --/--/1891
9. AGE (In years last birthday) 68-? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Springfield State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bi-lateral pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure due to generalized arteriosclerosis DUE TO (c) 5 years .		INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with mental deficiency		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1955 , 19 4-22 , 19 59 , that I last saw the deceased alive on 4-22 , 19 59 , and that death occurred at 1:05 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter Knopp		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-22-59	
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-59	
22c. NAME OF CEMETERY OR CREMATORY New-Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Knight		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Sent to SSM from B.C. on order of Supervisor of City Charities.
5/1/57 - E.T.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04187

Reg. Dist. No.

4197

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (Rural)</u>				c. LENGTH OF STAY IN 1b <u>1 y. 14 d.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1123 N. Eutaw Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Louise</u> Last <u>Schepler</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Edward Hitchcock</u>				14. MOTHER'S MAIDEN NAME <u>Kate Bartol</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT <u>Springfield State Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 18, 1958</u> , to <u>April 17, 1959</u> , that I last saw the deceased alive on <u>April 17, 1959</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Konstantin Weber</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>4/17/59</u>			
PHYSICIAN'S NAME (Type) <u>Konstantin Weber, M. D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/20/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>4600 Liberty Hgts. Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar	
John Doe		Male		White		1900-01-01		1950-01-01		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]	
12. Occupation		13. Education		14. Marital Status		15. Social Security No.		16. Date of Last Examination		17. Date of Last Medical Advice		18. Date of Last Hospital Admission		19. Date of Last Discharge		20. Date of Last Death Certificate		21. Date of Last Burial		22. Date of Last Cremation	
Teacher		High School		Married		123-45-6789		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	
23. Date of Last Death Certificate		24. Date of Last Burial		25. Date of Last Cremation		26. Date of Last Death Certificate		27. Date of Last Burial		28. Date of Last Cremation		29. Date of Last Death Certificate		30. Date of Last Burial		31. Date of Last Cremation		32. Date of Last Death Certificate		33. Date of Last Burial	
1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	
34. Date of Last Death Certificate		35. Date of Last Burial		36. Date of Last Cremation		37. Date of Last Death Certificate		38. Date of Last Burial		39. Date of Last Cremation		40. Date of Last Death Certificate		41. Date of Last Burial		42. Date of Last Cremation		43. Date of Last Death Certificate		44. Date of Last Burial	
1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	
45. Date of Last Death Certificate		46. Date of Last Burial		47. Date of Last Cremation		48. Date of Last Death Certificate		49. Date of Last Burial		50. Date of Last Cremation		51. Date of Last Death Certificate		52. Date of Last Burial		53. Date of Last Cremation		54. Date of Last Death Certificate		55. Date of Last Burial	
1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	
56. Date of Last Death Certificate		57. Date of Last Burial		58. Date of Last Cremation		59. Date of Last Death Certificate		60. Date of Last Burial		61. Date of Last Cremation		62. Date of Last Death Certificate		63. Date of Last Burial		64. Date of Last Cremation		65. Date of Last Death Certificate		66. Date of Last Burial	
1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	
67. Date of Last Death Certificate		68. Date of Last Burial		69. Date of Last Cremation		70. Date of Last Death Certificate		71. Date of Last Burial		72. Date of Last Cremation		73. Date of Last Death Certificate		74. Date of Last Burial		75. Date of Last Cremation		76. Date of Last Death Certificate		77. Date of Last Burial	
1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	
78. Date of Last Death Certificate		79. Date of Last Burial		80. Date of Last Cremation		81. Date of Last Death Certificate		82. Date of Last Burial		83. Date of Last Cremation		84. Date of Last Death Certificate		85. Date of Last Burial		86. Date of Last Cremation		87. Date of Last Death Certificate		88. Date of Last Burial	
1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	
89. Date of Last Death Certificate		90. Date of Last Burial		91. Date of Last Cremation		92. Date of Last Death Certificate		93. Date of Last Burial		94. Date of Last Cremation		95. Date of Last Death Certificate		96. Date of Last Burial		97. Date of Last Cremation		98. Date of Last Death Certificate		99. Date of Last Burial	
1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	
100. Date of Last Death Certificate		101. Date of Last Burial		102. Date of Last Cremation		103. Date of Last Death Certificate		104. Date of Last Burial		105. Date of Last Cremation		106. Date of Last Death Certificate		107. Date of Last Burial		108. Date of Last Cremation		109. Date of Last Death Certificate		110. Date of Last Burial	
1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15		1949-12-15	

Printed Name: John Doe
Address: 123 Main St, Baltimore, Md.
Registrar: [Signature]
Physician: [Signature]
Date: 1950-01-01

4198

CERTIFICATE OF DEATH

04188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville				c. LENGTH OF STAY IN 1b 2yr.4mo.5da.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown,				d. STREET ADDRESS Washington County Home			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Benjamin Middle Ernest Last Shirk				4. DATE OF DEATH Month 4 Day 15 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-28-75	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 4 Days 15 Hours 19 Min.		IF UNDER 24 HRS. Months 4 Days 15 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. 170-12-3056			
17. INFORMANT Springfield State Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bi-lateral Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction. (c) Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction. INTERVAL BETWEEN ONSET AND DEATH 4 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19 Month 4 Day 15 Year 19 59				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-12 , 19 56 , to 4-15 , 19 59 , that I last saw the deceased alive on 4-15 , 19 59 , and that death occurred at 6:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-15-59							
ACTUAL SIGNATURE Walter Knopp				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-17-59				22b. DATE THEREOF 4-17-59			
22c. NAME OF CEMETERY OR CREMATORY Springfield State Hospital				22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				ADDRESS Baltimore, Md.			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE Arthur S. Kuntz			
DATE APR 21 '59							

CERTIFICATE OF DEATH

MADE IN STATE COUNTY CITY		DECEASED NAME SEX AGE DATE OF BIRTH PLACE OF BIRTH	
OCCUPATION MARITAL STATUS COLOR		CAUSE OF DEATH IMMEDIATE UNDERLYING	
PLACE OF DEATH HOME HOSPITAL OTHER		DATE OF DEATH TIME OF DEATH	
SIGNATURE OF DECEASED SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN SIGNATURE OF CORONER	
SIGNATURE OF REGISTRAR SIGNATURE OF CLERK		SIGNATURE OF JUDGE SIGNATURE OF SHERIFF	

[Handwritten signatures and stamps at the bottom of the form]

1
B
M
X
10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

4199

04189

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY **Carroll** **MARYLAND**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Carroll**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **rural Westminster** c. LENGTH OF STAY IN 1b **7 years**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **rural Westminster**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **R 5 Warfieldsburg** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First **Howard** Middle **Newton** Last **Shockey** 4. DATE OF DEATH Month **April** Day **21** Year **1959**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH **March 21, 1870** 9. AGE (In years, log (thday) yrs. **89** IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **retired Barber** 10b. KIND OF BUSINESS OR INDUSTRY **Barber Shop** 11. BIRTHPLACE (State or foreign country) **Ohio** 12. CITIZEN OF WHAT COUNTRY? **U S A**

13. FATHER'S NAME **William Shockey** 14. MOTHER'S MAIDEN NAME **unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO. **312-28-7037** 17. INFORMANT **Paul Shockey** Address **R 5 Westminster, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Cerebral hemorrhage (hypertension)**
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Myocardial infarction**
DUE TO (c) **nephrotic**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **INTERVAL BETWEEN ONSET AND DEATH 3 days**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. **19** 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **1955**, 19____, to **4-21-**, 19**59**, that I last saw the deceased alive on **4-20-59**, 19____, and that death occurred at **1 A** M, from the causes and on the date stated above.

ACTUAL SIGNATURE **Wm C Jennette** ADDRESS (Street, city or town, state) **103 E Main Westminster** DATE SIGNED **4-21-59**

PHYSICIAN'S NAME (Type) **W. C. Jennette M. D.** **103 E. Main St. Westminster, Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 22b. DATE THEREOF **4-21-59** 22c. NAME OF CEMETERY OR CREMATORY **I.O.O.F Cemetery** 22d. LOCATION (City, town, or county) (State) **New Haven Indiana**

23. FUNERAL DIRECTOR'S SIGNATURE **John R. Byers** ADDRESS **Westminster, Maryland** 24a. REC'D BY REGISTRAR **DATE APR 22 '59** 24b. REGISTRAR'S SIGNATURE **Arthur L. Hana**

the first

Figure 6

7001-10-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4200

CERTIFICATE OF DEATH

04190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 91 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 1012 N. Gilmore Street	
3. NAME OF DECEASED (Type or print) First Eugene Middle Last Simpson		4. DATE OF DEATH Month April Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13, 1907
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Mark Simpson		14. MOTHER'S MAIDEN NAME Nealy Battey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Provident Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular accident 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilis and extensives suppurating bed sores DUE TO (c) Far advanced bilateral pulmonary tuberculosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 6 , 19 59 , to April 19 , 19 59 , that I last saw the deceased alive on April 19 , 19 59 , and that death occurred at 9:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgars M. Maculans		ADDRESS (Street, city or town, state) Henryton, Maryland	
DATE SIGNED 4-19-59		M.D.	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D.		Henryton State Hospital, Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Apr 22	
22c. NAME OF CEMETERY OR CREMATORY St Calvary		22d. LOCATION (City, town, or county) (State) AA	
23. FUNERAL DIRECTOR'S SIGNATURE A. Habsted		ADDRESS 918 Dundas	
24a. REC'D BY REGISTRAR DATE APR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4201

CERTIFICATE OF DEATH

04191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #3		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 6707 14th St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First JEFFERSON Middle PAUL Last SMITH		4. DATE OF DEATH Month APRIL Day 2 Year 19 59				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/03	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 2 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent of Press		10b. KIND OF BUSINESS OR INDUSTRY Room Newspaper		11. BIRTHPLACE (State or foreign country) Mt. Airy, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David W. Smith			14. MOTHER'S MAIDEN NAME Alice V. Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-07-7116		17. INFORMANT Mrs. Emma A. Smith, 6707 14th St., N.W. Washington, D. C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary occlusion DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 minutes 3 years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February, 1956 , to 27 March, 1959 , that I last saw the deceased alive on 27 March, 1959 , and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Seruch T. Kimble M.D. 429 Pershing Drive, S.S., Md 20959 PHYSICIAN'S NAME (Type) Seruch T. Kimble						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/6/59		22c. NAME OF CEMETERY OR CREMATORY PINE GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) MT. AIRY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pomphrey, Inc. Raymond E. Pomphrey			ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR APR 6 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04192

Reg. Dist. No.

4202

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keymar	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS Route #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clifford Middle Leroy Last Stansbury		4. DATE OF DEATH Month April Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1938
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Stansbury		14. MOTHER'S MAIDEN NAME Elizabeth Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mr. William J. Stansbury, Keymar, Md. R #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull, left arm and femur 814X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Motorcycle accident	
20c. TIME OF INJURY Month, Day, Year 4:45 p.m. 4 20 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Place of death	20f. (City or town) (County) (State) Taneytown Carroll Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE JAMES J. MARSH		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 23, 1959	22c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery	22d. LOCATION (City, town, or county) (State) Keysville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son		24a. REC'D BY REGISTRAR DATE APR 22 '59	
ADDRESS Taneytown, Maryland		24b. REGISTRAR'S SIGNATURE Arthur E. Hous	

4203

CERTIFICATE OF DEATH

04193

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City (Balto.)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4mos. 26days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 437 N. Bouldin St.	
3. NAME OF DECEASED (Type or print) First Charles Middle Albert Last Stengel		4. DATE OF DEATH Month April Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 12, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet maker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Stengel		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 313-05-1779	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with wither diseases of unknown or uncertain cause with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 20, 1958 , to April 16, 1959 , that I last saw the deceased alive on April 16, 1959 , and that death occurred at 11:10AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i> M.D.		ADDRESS (Street, city or town, state) Springfield Hospital	
DATE SIGNED 4/16/59			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/59	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E. Baltimore St.		24a. REC'D BY REGISTRAR DATE APR 20 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John A. Johnson		Male		45		Jan 15, 1858		Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
1234 Main St. Baltimore		Teacher		Heart Disease		3 weeks		Home	
DATE OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE		RESPIRATIONS	
Jan 20, 1903		10:00 AM		101.0		90		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
J. H. Smith		A. B. Jones		John A. Johnson		W. D. Green		H. L. Brown	
DATE OF REGISTRATION		PLACE OF REGISTRATION		OFFICE OF REGISTRAR		OFFICE OF HEALTH		OFFICE OF VITALS	
Jan 22, 1903		Baltimore		City and County		State of Maryland		U.S. Department of Health	

ORIGINAL FILED IN 1903-2000

This certificate is a true and correct copy of the original as filed in the office of the Registrar of the State of Maryland, Baltimore, Maryland, on the 22nd day of January, 1903.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4204

CERTIFICATE OF DEATH

04194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.I. #1</u>		d. STREET ADDRESS <u>R.I. #1</u>	
3. NAME OF DECEASED (Type or print) <u>John Warren Streig</u> First Middle Last		4. DATE OF DEATH <u>April 17</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/31/1885</u> 9. AGE (In years last birthday) <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Streig</u> (Streig)		14. MOTHER'S MAIDEN NAME <u>Marg. Wentz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2-12-32-3429</u>	
17. INFORMANT <u>Marg. E. Streig</u> Address <u>Manchester Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8 hrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> 19 <u>49</u> , to <u>April 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 16</u> , 19 <u>59</u> , and that death occurred at <u>4:30 p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u> M.D. <u>Manchester, Md</u>		DATE SIGNED <u>4/18/59</u>	
PHYSICIAN'S NAME (Type) <u>W H Foard, M.D.</u>		<u>Manchester, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bazelon Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Manchester Md #1 (Carroll)</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fredrick Bucher</u> ADDRESS <u>Shinner Rd</u>		24a. REC'D BY REGISTRAR <u>APR 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Brown</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4205

CERTIFICATE OF DEATH

04195

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 015 SPRINGFIELD STATE HOSPITAL				d. STREET ADDRESS 2011 E. OLIVER STREET			
3. NAME OF DECEASED (Type or print) First FRANK Middle BAKER Last TAWNEY				4. DATE OF DEATH Month 4 Day 9 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-89	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONARY ENGINEER BALTO GAS & ELK.				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME WILLIAM TAWNEY				14. MOTHER'S MAIDEN NAME KATE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 212-07-6207		17. INFORMANT H. KLAATSCHE M.D. Address SPRINGFIELD HOSP	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE year DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-8-58 19 58 , to 4-9 19 59 , that I last saw the deceased alive on 4-9 19 59 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRINGFIELD STATE HOSPITAL DATE SIGNED 4/9/59							
ACTUAL SIGNATURE Heinz H. Klaatsch M.D.				PHYSICIAN'S NAME (Type) HEINZ H. KLAATSCHE SYKESVILLE / MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-13-59		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Jr. ADDRESS 6009 Hayford Road				24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Catharine S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4206

CERTIFICATE OF DEATH

04196

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakley 18x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) First John Middle Albert Last Thomas		4. DATE OF DEATH Month April Day 10 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Hurry, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hilliary Thomas		14. MOTHER'S MAIDEN NAME Annie Thomas Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) War I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rosanna Thomas-Oakley, St. Mary's Co., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular accident DUE TO (c) Moderately advanced pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Feb. 27, 1959 to Apr. 10, 1959 , that I last saw the deceased alive on April 10, 1959 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgars M. Macudans M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland	
DATE SIGNED 4-10-59			
PHYSICIAN'S NAME (Type) Edgars M. Macudans, M. D. Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/13/59	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	22d. LOCATION (City, town, or county) (State) Bushwood, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clark Mattingley, Funeral Home Inc.		24. REC'D BY REGISTRAR DATE 4/10/59	
24b. REGISTRAR'S SIGNATURE Charles S. Thomas			

APR 14 1959

CERTIFICATE OF DEATH

6208

DATE OF DEATH 1957		PLACE OF DEATH HOME	
DECEASED JOHN J. JONES		SEX MALE	
AGE 65		RACE WHITE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION FARMER		RELIGION METHODIST	
DATE OF BIRTH 1912		PLACE OF BIRTH BALTIMORE, MD	
MOTHER'S NAME MARY J. JONES		FATHER'S NAME JOHN J. JONES	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE CORONARY THROMBOSIS		MEDICAL HISTORY HYPERTENSION	
PREVIOUS ILLNESS NONE		TREATMENT NONE	
DATE OF DEATH 1957		PLACE OF DEATH HOME	
DECEASED JOHN J. JONES		SEX MALE	
AGE 65		RACE WHITE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION FARMER		RELIGION METHODIST	
DATE OF BIRTH 1912		PLACE OF BIRTH BALTIMORE, MD	
MOTHER'S NAME MARY J. JONES		FATHER'S NAME JOHN J. JONES	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE CORONARY THROMBOSIS		MEDICAL HISTORY HYPERTENSION	
PREVIOUS ILLNESS NONE		TREATMENT NONE	

10 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4207

CERTIFICATE OF DEATH

04197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>		d. STREET ADDRESS <u>RURAL</u>	
3. NAME OF DECEASED (Type or print) <u>FUSHIA</u> First Middle Last		4. DATE OF DEATH <u>APRIL 17</u> Day Month Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 22-1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LUTHER HAYES</u>	
14. MOTHER'S MAIDEN NAME <u>BECKY MURDOCK</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JOHN T. TUCKER</u> Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular hypertensive disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 26</u> , 19 <u>59</u> , to <u>Apr 19</u> , 19 <u>59</u> , and that death occurred on <u>Apr 17</u> , 19 <u>59</u> , at <u>4 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D.		ADDRESS (Street, city or town, state) <u>15 Remfer ave</u> DATE SIGNED <u>4/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr E. Reese Wilkens</u>		<u>Westminster Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>	22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr Hartzler & Sons</u>		ADDRESS <u>Union Bridge</u>	
24a. REC'D BY REGISTRAR <u>APR 13 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Pomeroy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4208

CERTIFICATE OF DEATH

04198

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>S.</u> Last <u>Valentine</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1874</u>		9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sylvester Valentine</u>				14. MOTHER'S MAIDEN NAME <u>? Whitmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Carroll Valentine, Taneytown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Chronic Parenchymatous Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Syrs.</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/20</u> , 19 <u>59</u> , to <u>4/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/29</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. S. McVaugh</u> M.D.				ADDRESS (Street, city or town, state) <u>Taneytown Md.</u>			
PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>				DATE SIGNED <u>5/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keysville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Fuss</u> <u>C. O. Fuss & Son</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4209

CERTIFICATE OF DEATH

04199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5yrs.6mos.12days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Voorhees Last Voorhees		4. DATE OF DEATH Month April Day 28 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1870
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown John A. Voorhees		14. MOTHER'S MAIDEN NAME Unknown Mary D. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 , to April 28, 1959 , that I last saw the deceased alive on April 27, 1959 , and that death occurred at 7:04A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		DATE SIGNED 4/28/59	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-59	
22c. NAME OF CEMETERY OR CREMATORY Edenwood		22d. LOCATION (City, town, or County) (State) Springfield, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Wright		24a. REC'D BY REGISTRAR MAY 1 '59	
ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE Charles E. Hines	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11103

CERTIFICATE OF DEATH

11103

Blank certificate form with faint lines and text for recording death information.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4210

CERTIFICATE OF DEATH

04200

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville.</u>		c. LENGTH OF STAY IN 1b <u>32yr.10mo.14da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>2103.2</u>	
4. DATE OF DEATH First Middle Last <u>Randolph</u> <u>J</u> <u>Walker</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-21-1889</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> 11. BIRTHPLACE (State or foreign country) <u>Florida</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles P. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Lucy G. Hurd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT Address <u>Springfield State Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia, hebephrenic type</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>8-1955</u> 19 <u>4-31</u> 19 <u>59</u> , that I last saw the deceased alive on <u>4-14</u> 19 <u>59</u> , and that death occurred at <u>3:10</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>4-14-59</u> ACTUAL SIGNATURE <u>Walter Knopp</u> M.D. PHYSICIAN'S NAME (Type) <u>Walter Knopp, M.D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knapp</u>		24a. REC'D BY REGISTRAR DATE <u>APR 17 '59</u>	
ADDRESS <u>Hagerstown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

•

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G242 5-6-59 et

CERTIFICATE OF DEATH

04201

Reg. Dist. No.

4211

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shenandoah, Connahant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shenandoah</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sykesville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace J. Walfien</u>		4. DATE OF DEATH <u>April 26</u> 19 <u>59</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1970</u> 89 yrs.
9. AGE (In years last birthday) <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Mc Kee</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT <u>Mr. H. C. Hillingham</u>		Address <u>1322 Madison St. N.W. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>ADVANCED SENILE DETERIORATION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u> <u>20 yrs</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1935</u> , 19 <u> </u> , to <u>26 April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>25 April</u> , 19 <u>59</u> , and that death occurred at <u>12:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr.</u>		DATE SIGNED <u>4/26/59</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg, Sykesville P.O., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur W. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

IN THE COUNTY OF

STATE OF MARYLAND

DECEASED

IN THE COUNTY OF

STATE OF MARYLAND

DECEASED

IN THE COUNTY OF

STATE OF MARYLAND

DECEASED

IN THE COUNTY OF

STATE OF MARYLAND

DECEASED

IN THE COUNTY OF

STATE OF MARYLAND

DECEASED

IN THE COUNTY OF

STATE OF MARYLAND

DECEASED

IN THE COUNTY OF

STATE OF MARYLAND

DECEASED

IN THE COUNTY OF

STATE OF MARYLAND

05491

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1yr. 8days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Stuart</u> Last <u>Wantz</u>				4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-68</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elias Wantz</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Rineman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to Cachexia</u> DUE TO (c) <u>Carcinomia of prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour <u>---</u> a. m. <u>---</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from <u>April 1, 19 58</u> to <u>April 9, 19 59</u> , that I last saw the deceased alive on <u>April 9, 19 59</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter Knopp</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			
DATE SIGNED <u>4-9-59</u>							
PHYSICIAN'S NAME (Type) <u>Walter Knopp, M.D.</u> <u>Sykesville, Maryland</u>							
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial April 13 1959</u>		<u>April 13 1959</u>		<u>St. Andrew's Episcopal Cemetery</u>		<u>Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Newell</u>				ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

1959

Phone call; Penell late in filing this -
5/14/59 - Mrs.

4213

CERTIFICATE OF DEATH

04202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lee OWINGS WARFIELD, Sr.</u>		4. DATE OF DEATH Month Day Year <u>H 22 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua W. Warfield</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Polk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-24-5485</u>	
17. INFORMANT <u>Mrs. Blanche B. Warfield - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized cerebral and vascular arteriosclerosis</u> DUE TO (c) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 years</u> <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-24</u> , 19 <u>58</u> , to <u>4-22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-23</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrand R. Gau</u>		DATE SIGNED <u>4-22-59</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand R. GAU</u>		<u>Sykesville</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Spaight</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G243 6-5-59 at
4214

CERTIFICATE OF DEATH

04203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)				c. LENGTH OF STAY IN 1b 2 Yrs., 2 Dys.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1200 Valley Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Annie Middle Cheseltine Last Wells				4. DATE OF DEATH Month 4 Day 4 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1872	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ernest Wells				14. MOTHER'S MAIDEN NAME Mary Hammett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction, - Latent syphilis. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH Months Days Years
21. I certify that I attended the deceased from 4-3 , 19 57 , to 4-4 , 19 59 , that I last saw the deceased alive on 4-3- , 19 59 , and that death occurred at 12:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-4-59 ACTUAL SIGNATURE Rita S. Glahan M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Rita S. GLAHAN Sykesville, Maryland							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-59		22c. NAME OF CEMETERY OR CREMATORY Catholic Cem.		22d. LOCATION (City, town or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Forley Funeral Home-Catonville Md ADDRESS				24a. REC'D BY REGISTRAR DATE APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4215

CERTIFICATE OF DEATH

04204

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u>		c. LENGTH OF STAY IN 1b <u>34 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dana</u> Middle <u>(W)</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1925</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>various</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter Butler</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-28-5538</u>	
17. INFORMANT Address <u>Mabel Williams - Mount Airy, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Several Months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1950</u> to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>59</u> , and that death occurred at <u>9:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>4/28/59</u>			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.			
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		<u>Mount Airy, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-1-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. M. Waltz, Winfield, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED WALTER B. BULLER		2. SEX MALE		3. AGE 67	
4. DATE OF DEATH SEP 10 1952		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. STREET ADDRESS 1234 E. BALTIMORE ST.		8. CITY BALTIMORE		9. STATE MD	
10. OCCUPATION RETIRED		11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL	
13. SIGNATURE OF DECEASED WALTER B. BULLER		14. SIGNATURE OF WITNESS JOHN D. SMITH		15. SIGNATURE OF PHYSICIAN DR. J. H. JONES	
16. SIGNATURE OF CLERK JOHN D. SMITH		17. SIGNATURE OF REGISTRAR JOHN D. SMITH		18. SIGNATURE OF DEPUTY REGISTRAR JOHN D. SMITH	

DO NOT WRITE IN THESE SPACES

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH
 AND IS NOT VALID FOR ANY OTHER PURPOSES
 IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THE RECORDS
 AND TO PROVIDE THE BEST POSSIBLE SERVICE TO THE PUBLIC
 ANY CHANGES OR CORRECTIONS SHOULD BE MADE IMMEDIATELY
 AND SHOULD BE APPROVED BY THE DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4216

CERTIFICATE OF DEATH

04205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15yrs. 2mos. 22days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) No address - brought here by	
3. NAME OF DECEASED (Type or print) First Franklin Middle WILLIAMS Last WILLIAMS		4. DATE OF DEATH Month April Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1915
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.	IF UNDER 24 HRS. Months 44 Days 44 Hours 44 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia due to hemorrhagic nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 590x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency without psychosis			
INTERVAL BETWEEN ONSET AND DEATH Months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19 a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 to April 21, 1959 that I last saw the deceased alive on April 21, 1959 , and that death occurred at 2:45P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustini del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/22/59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/22/59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR APR 23 '59	
ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

012005

CERTIFICATE OF DEATH

4218

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH Maryland		5. DATE OF BIRTH Jan 1, 1900		6. PLACE OF DEATH Baltimore, Maryland	
7. OCCUPATION Teacher		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. DATE OF DEATH Dec 15, 1945		11. TIME OF DEATH 10:30 AM		12. PLACE OF INTERMENT Catholic Cemetery	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF WITNESSES John Smith, Mary Jones		15. SIGNATURE OF PHYSICIAN Dr. J. K. Brown	
16. SIGNATURE OF REGISTRAR John Doe		17. SIGNATURE OF CLERK Mary Jones		18. SIGNATURE OF NOTARY John Doe	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO PROVIDE THE NECESSARY INFORMATION TO THE PUBLIC. THE DEPARTMENT IS NOT RESPONSIBLE FOR THE CONSEQUENCES OF THE USE OF THIS CERTIFICATE FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04206

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
3. NAME OF DECEASED (Type or print) First Howard Middle Frank Last Wollet		4. DATE OF DEATH Month April Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 7, 1870
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wollet		14. MOTHER'S MAIDEN NAME Rachel -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. Recent bilateral subdural hemorrhage; not fresh.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 6, 1959 to April 20, 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 8:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 4/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Balto Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Donovan		24a. REC'D BY REGISTRAR DATE APR 23 '59	
ADDRESS 3808 Roland Ave		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

01280

CERTIFICATE OF DEATH

PLACE OF DEATH		RESIDENCE		DATE OF DEATH	
Home		Home		April 10, 1933	
Age		Sex		Race	
65		Male		White	
Married		Single		Occupation	
Yes		No		None	
Cause of Death		Immediate Cause		Underlying Cause	
Heart Failure		Heart Failure		Heart Failure	
Duration of Illness		Duration of Illness		Duration of Illness	
10 days		10 days		10 days	
Place of Burial		Place of Burial		Place of Burial	
Home		Home		Home	
Buried		Buried		Buried	
Yes		No		No	
Signature of Physician		Signature of Physician		Signature of Physician	
[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature	
April 10, 1933		April 10, 1933		April 10, 1933	
Signature of Registrar		Signature of Registrar		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature	
April 10, 1933		April 10, 1933		April 10, 1933	
Signature of Coroner		Signature of Coroner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature	
April 10, 1933		April 10, 1933		April 10, 1933	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 2mos. 28days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 26 Avenal Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Minnie		Middle Margaret Neumeister		Last Worteck		4. DATE OF DEATH Month April Day 27 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 10, 1893		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - clerk		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Neumeister				14. MOTHER'S MAIDEN NAME Louise Knoblock					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-26-9901		INFORMANT Springfield Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic depressive reaction.								INTERVAL BETWEEN ONSET AND DEATH Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from January 29, 19 59 to April 27, 19 59 , that I last saw the deceased alive on April 27, 19 59 , and that death occurred at 8:45A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Edmund Lusthaus		M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 4/27/59			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/30/59		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN Cem.		22d. LOCATION (City, town, or county) (State) BALTO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Hartley Miller				ADDRESS 2334 Jefferson St.		24a. REC'D BY REGISTRAR DATE APR 29 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

015

VS A15 (4)
15M 9/58

04503

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4219 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04208

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster R 6		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Westminster R.F.D.6			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Smallwood, Md.				f. STREET ADDRESS Smallwood		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERNARD First Middle Last				4. DATE OF DEATH Wuest Month Day Year Apr 9 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 6, 1899	
				9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret Accountant		10b. KIND OF BUSINESS OR INDUSTRY Country Club		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Adolph Wuest				14. MOTHER'S MAIDEN NAME Thresa Flick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-10-9190		17. INFORMANT Address Mrs. Edith Wuest R. 6 Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hanging DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 4-9 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Smallwood Carroll Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/9/59	
EXAMINER'S NAME (Type) JAMES T. MARSH				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-59		22c. NAME OF CEMETERY OR CREMATORY Evergreen Gardens		22d. LOCATION (City, town, or county) (State) Finksburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE APR 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hall			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH

DATE OF BIRTH
SEX

Barthol

Barthol

Barthol

Barthol

Barthol

DATE OF BIRTH
SEX

Barthol

Barthol

Barthol

NO

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

Barthol

CERTIFICATE OF DEATH

04209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville				c. LENGTH OF STAY IN 1b 3yr. 4mo. 20da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 417 E. 28th. St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Malster — Yeager				4. DATE OF DEATH Month Day Year 4 21 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-6-97	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John T. Yeager		14. MOTHER'S MAIDEN NAME Ellie--- (Ella Miles)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown unknown		16. SOCIAL SECURITY NO. 215-10-2428		17. INFORMANT Address Records Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) encephalomalacia - sudden 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with central nervous system syphilis, meningoencephalitic, with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-1-1955 19, to May 21 1959 that I last saw the deceased alive on May 21 1959 , and that death occurred at 10:50 A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 4-21-59							
ACTUAL SIGNATURE Walter Knopp M.D.				PHYSICIAN'S NAME (Type) Walter Knopp, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/25/59		22c. NAME OF CEMETERY OR CREMATORY Louden Park Cem.	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Liekner				24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04210

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll 4221 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 9 m 24 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville, Md. 10X-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Franklin Last Zecher		4. DATE OF DEATH Month 4 Day 25 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-82
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dawson D. Zecher		14. MOTHER'S MAIDEN NAME Amanda Dutrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-36-2511	
17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS OR INJURIES RELATED TO THE DEATH (USE FOR PART I (a)) C.B.S. assoc with circulatory disturbances, with cerebral arteriosclerosis, with psych.reaction. Fracture of the neck of the left humerus			INTERVAL BETWEEN ONSET AND DEATH days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) pt. fell in the bathroom at his house while out on parole	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4 p. m. 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Burkittsville, Frederick, Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James J. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-59	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) Burkittsville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co. Middletown		24a. REC'D BY REGISTRAR DATE APR 29 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

